Maternal and Child Health Services
Title V Block Grant

State Narrative for Nevada

Application for 2011
Annual Report for 2009

Document Generation Date: Thursday, September 30, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

/2010//2011/Nevada's Assurances and Certifications are signed and filed in the office of the Chief of the Bureau of Child, Family, and Community Wellness, Deborah Harris. Ms. Harris serves as the MCH Director for Nevada. This office is located at 4150 Technology Way, Suite 101, Carson City, NV 89706. Ms. Harris can be reached at mcanfield@health.nv.gov or at 775-684-4285. //2010//2011//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2010/ The Maternal and Child Health Advisory Board is a Governor appointed board. It is composed of 11 members who represent legislators, pediatricians, mental health providers, dentists, and ob-gyns. The northern urban area, southern urban area and the eastern rural areas are represented. The board annually produces their priority areas. For 2009 and 2010, they are access to prenatal care, Immunization rates, dental sealants, and access to mental health screenings. See their website at http://www.health.nv.gov/MCH.htm

The MCH board priorities were used to guide the budget and activity changes for the future year plan. The board members were each assigned specific performance measures and worked with state MCH staff to produce the narrative text. In addition community partners and affiliated organizations related to each performance measure were consulted. All board members will review the entire block grant a few weeks prior to the public meeting . Chairs of the Northern Nevada MCH Coalition and the newly formed Southern Nevada MCH Coalition will also attend the public hearing. Special effort was made to invite key stakeholders, affiliated advisory/task forces to the public meeting for more comprehensive views, input, and regional representation. Public notices were on the Health Division website. The Public Hearing was held July 10, 2009 during the meeting of the MCH Advisory Board. Written comments were solicited. Copies of the application were available by contacting the Bureau of Child, Family, and Community Wellness. Copies continue to be posted at the State Public Library and the Nevada Early Intervention Services in Reno, Las Vegas and Elko and the Health Divison website. This application represents priorities established by the Year 2005 Needs Assessment with annual updates and guidance by the MCH Advisory Board. //2010////2011//The MCH BG applicationis on the Health Division website as well as copies to the link were sent out to all listservs. Our needs assessment convened focus groups throughout the state to discuss MCH and CYSHCN issues. Review of the MCH BG will be addressed at the Advisory Board meeting. /2011/

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

In 2010 we celebrate the 75th Anniversary of Congress passing the Social Security Act, which contained the initial key legislation which established Title V. Every five years State Title V agencies are required to conduct needs assessments and to use the findings of the assessment to identify priorities and guide future resource allocation and program planning.

The goals of Nevada's Title V MCH Needs Assessment are to determine Nevada's priority needs for the maternal and child health population; assess stakeholder and Nevada State Health Division (NSHD) capacity to address the identified needs; and utilize the findings to address priorities strategically with existing and new partners while ensuring that programs which are funded by Nevada's Title V Block Grant are used to meet those needs and are held accountable.

Nevada's Needs Assessment includes:

•Assess the needs and gaps at the service delivery level through:

o A review of current priority areas;

o An online survey asking stakeholders to rank potential needs and discuss specific areas of concern;

o Regional face-to-face focus groups to further review and rank potential needs, discuss local resources and brainstorm solutions.

•Nevada State Health Division and MCH stakeholder capacity was assessed by:

o An online survey of MCH staff and other stakeholders;

o Feedback from Nevada's Maternal and Child Health Advisory Board; and

o Qualitative and quantitative data from service providers.

For the purposes of this Needs Assessment Report, focus groups were conducted in Las Vegas, Reno, and Elko. Though turnout was lower than initially planned, the collaborative setting allowed for open exchanges and brainstorming that would not have been gained had the groups been larger. The focus groups were supplemented by the online survey.

Focus group invitees included: MCHAB members; Northern Nevada MCH Coalition and the newly formed Southern Nevada MCH Coalition members; key stakeholders including providers, families with children with special health care needs; and affiliated advisory/task forces including the Nevada Advisory Council for CYSHCN, the Perinatal Substance Abuse Prevention Subcommittee, the five regional Oral Health Coalitions, and the Youth Action Council.

The 2010 Needs Assessment updates the 2005 Needs Assessment, supplemented by smaller-scale needs assessments by MCH related grants housed in Title V and by community partners. These are a few of the recent needs assessments reviewed and incorporated by MCH staff: Kindergarten Survey, Head Start Needs Assessment, Southern Nevada Health Districts prenatal population (GIS mapping), Rural Respite for CYSHCN, and others. The Oral Health Program has completed an assessment of the oral health of third graders. Surveillance of injury, oral health, low birth weights, pregnant women's substance abuse, continues on a regular basis.

III. State Overview

A. Overview

Nevada's Maternal and Child Health Program is dedicated to improving the health of families, with emphasis on women, infants and children, including Children with Special Health Care Needs, by promoting, assuring and providing health education, prevention activities, quality assurance and health care services. Over the past two years the MCH program has undergone a transformation to streamline processes, integrate programs and move down the MCH pyramid toward becoming an organization with a strong public health approach of monitoring, assurance, and policy development.

Nevada is a huge state in land mass. The state is a semi-arid, largely mountainous with numerous valleys of primarily north-south orientation. Approximately 83% of Nevada's land area is under the jurisdiction of the Bureau of Land Management; the remaining 17% is under private ownership or state and local jurisdiction. Nevada has thirteen Indian colonies or reservations statewide and six military bases located in five counties.

One of the main challenges to health care delivery in Nevada has been explosive population growth. For 19 consecutive years, Nevada has been the fastest growing state in the nation. Estimates indicate that by 2025 Nevada will rank the 15th largest among all states, with approximately 5,000 people moving per week to Las Vegas alone. Many families moved to Nevada for the prosperity and opportunity associated with a previously rapidly growing economy. Nevada also echoes a nationwide population shift to warmer climates as the population ages and traditional sources of income and employment dwindle in northern states. Regardless of the reason, an increasing population strains overall public health funding. In the case of health, an increased population means increased numbers of people to educate and influence to make good choices.

Nevada's sheer geographical size also increases the difficulty health related intervention. Nevada is the 7th largest state in the nation, totaling 110,540 square miles. Serving an area this large challenges prevention programs because of the distances involved and the requirements of a diverse population. Nevada has only two areas of dense population, Reno and Las Vegas, located approximately 450 miles apart. The largest populated area, Clark County (Las Vegas), currently makes up 72 percent of the total state population. Nevada's urban areas struggle with many of the problems associated with urban living but also with an unusually high cost of living, especially for housing, relative to low wages and insecure work in the service industries that make up a large number of available jobs in these areas. The remainder of Nevada is rural, with 15 of its 17 total counties classified as rural or frontier, an area the combined size of Maine, Maryland, Massachusetts, Vermont, New Hampshire, New Jersey, Connecticut and Rhode Island. In Nevada, the poverty level in rural and urban areas is comparable, but access to many services is severely limited, especially for medical care and health information. The distances to other areas prohibit many residents from receiving services at all. Rural areas may also lack access to utilities, technology, education, and employment, while having a more limited infrastructure than urban areas.

Challenges posed by this constant intense migration and large geographical size, Nevada must address ongoing challenges to public health delivery because of its transient population. Nevada is one of the top destination spots in the United States, with visitors putting an additional strain on fiscal and human resources. In 2004, there were approximately 50,500,000 visitors to Nevada, an increase of 4.0 percent since 2003. In 2005, the number of visitors in Nevada increased .8 percent to over 51,500,000. Nevada also has a large homeless population, both chronic and transitional. In 2007, homelessness in Nevada was almost double the national rate.

Because of the lack of affordable housing and rising unemployment, many families are living in motels or other temporary housing. Youth living in shelters or those lacking permanent housing

face problems enrolling and participating in school, and since 2007, local and state homeless groups are reporting an increase of 61% in homelessness (National Law Center for Homelessness and Poverty). These fluctuating and mobile populations increase the difficulty of indentifying and tracking disease.

The United States Census Bureau expects Nevada to become a minority-majority state in the coming decades. Currently, Nevada's population is comprised of 37.9 percent minority races. In 2006, the estimated racial/ethnic composition of Nevada was 62.2 percent White, 23.2 percent Hispanic/Latino, 6.9 percent African American, 6.3 percent Asian/Pacific Islander and the remaining 1.4 percent Native American or Alaskan Native. The minority population is expected to increase dramatically during the period of the grant and in ensuing years. Hispanic teens are the largest population of pregnant teens with 2,300 teen births in 2007. This coincides with a lack of employment for Hispanics in the current economy: according to Bureau of Labor Statistics, from 2007 to 2010 Hispanics in the Southwest were hardest hit by unemployment, almost double the rate, because of their disproportionate number in the construction industry. The rising cost of gold is putting new life back into some of Nevada's communities with new mines being developed and old mines reopened. Nevada was the leading gold producing state in the country in 2006. Most mines are located in the rural and frontier regions of Nevada, although what effect this has on the regions is not yet clear.

Health Coverage

In addition to the fiscal situation there are many factors that impact the health services delivery system in the state. The extreme rurality of most of Nevada is one that leads to many challenges in developing a health services delivery system in the state. About 12% of Nevadans live in rural and frontier communities, most of which are remote from urban centers. This is compounded by a lack of providers for both primary and specialty care that is even seen in the most urban communities. MCH collaborates with the Primary Care Office who is responsible for conducting the surveys necessary to establish Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs). HPSAs can be primary care, dental or mental health shortages and have a very high patient to provider ratio. These designations help with the recruitment of providers to underserved areas.

Primary Care Office works closely with a number of key organizations involved in the development of primary care resources throughout the state. Included are Nevada Health Centers, Office of Rural Health, University of Nevada School of Medicine, Nevada Rural Hospital Partners, Area Health Education Centers, Washoe County Access to Health Care Network, and Clark County Health Access Consortium.

Access to healthcare is a priority for MCH. Nevada's Medicaid and Children's Health Insurance Program are managed b the Division of Health Care Financing and Policy. The Nevada Division of Health Care Financing and Policy contracts with two managed care organizations, which provide health care to Medicaid eligible individuals.

Nevada Check Up (the Title XXI State Children's Health Insurance Program) continues to grow as more eligible families learn about program availability. The program benefits children who are not eligible for traditional Medicaid and may not otherwise have access to health care. In 2009 Medicaid provided services to over 510,000 persons. The monthly average of children enrolled in Nevada Check Up for 2008 was 29,075. The complexity arises with the economic downturn and more families are eligible for Medicaid which reduces the need for Nevada Check Up, therefore the expectation is that fewer children will be enrolled in Nevada Check Up and the number of those enrolled in Medicaid will rise in the future.

The Nevada Health Insurance Flexibility and Accountability (HIFA) Waiver program was adopted in 2007 by the State of Nevada within the Section 1115 of the Social Security Act. This project is funded under Title XXI of the Social Security Act. Nevada has expanded eligibility to individuals

not otherwise eligible under the Nevada Medicaid program. The Nevada HIFA waiver program includes two eligibility groups and is intended to increase coverage of uninsured individuals within the State of Nevada.

The HIFA-P program is designed for uninsured pregnant women who do not qualify for Medicaid and whose net annual income is above 133% and up to and including 185% of the Federal Poverty Level (FPL). HIFA-P coverage is a comprehensive pregnancy-related health package. HIFA-P includes all pregnancy-related services outlined in the Medicaid Services Manual and uses the Nevada Medicaid Provider Panel. Eligibility for this coverage group is completed by the Division of Welfare and Supportive Services. The Bureau works closely with the Division of Health Care Financing and Policy to ensure services needed by the MCH populations are provided.

Designed to help needy families achieve self sufficiency, Temporary Assistance for Needy Families in Nevada furnishes financial, medical and support services such as child care,

The Maternal and Child Health Program in Nevada has had many successes and will continue to address efforts for our populations well being.

Policy/Legislative Sessions

Nevada is one of only six states that have biennial legislative sessions, and the Nevada Legislature meets for 120 days during each odd-numbered year. This provides NSHD with the opportunity to better identify issues and work with the interim Legislative Committee on Health Care to develop policy and propose legislation to tackle public health needs. However, given the time constraints and constitutional requirements of the biennial sessions, the challenge lies in the workload of Nevada Legislators and the fiscal health of the state, and not all needs can be addressed. Nevada does not always have a large federal to state match for funding public health. NSHD has leveraged that position to work cooperatively with our stakeholders, the district health authorities and rural communities in procuring necessary grant dollars.

With the current economic challenges expected to continue for a period of time, it is expected that our programs will need to show quality cost effective program planning, development and implementation. MCH is well situated for these expectations. Over the past two years our Bureau has undergone a strategic planning reorganization, streamlining processes, organizing programs to better suit the target population. MCH is moving efforts "down the pyramid" towards infrastructure building based on our economic reality that serves a greater population with sustainable efforts.

Our work with our MCH Advisory Board for direction and guidance on policy issues, our efforts of our partners as an advocacy voice and offers of education to our legislative leaders through hosted events has increased our outreach and education efforts statewide. Our new MCHAB chair is enthusiastic, knowledgeable and action oriented. Subcommittees have been formed to focus efforts and address needs. The Access to Prenatal Subcommittee has worked for the past year to improve access and increase awareness and knowledge of the issues of prenatal care. Our Perinatal Substance Abuse Prevention Subcommittee has developed a strategic plan and is currently looking to expand its reach to more heavily focus on all substances, and the Newborn Screening Advisory Board has met only twice, but members are anxious to start addressing issues around screening and monitoring all infants born in Nevada and to improving processes. Our Children with Special Health Care Needs Council composed of providers, care coordinators, and parents meet to address issues of this special population. In the process of reorganizing to develop a strategic plan, technical assistance from MCH will be requested in 2010.

Maternal Health

The Medicaid Managed Care Options make a good faith effort to screen Title XIX and Title XXI

pregnant women enrolled in a MCO for maternal high risk factors. The Maternity Risk Screening Form helps identify and meet the need for medical and non --medical services. These services are defined as preventive and or person care services or home health care, substance abuse services, and care coordination services in addition to maternity care. Any identification of high-risk factors will require the Primary Care Provider, Obstetrician provider, registered nurse or licensed practical nurse to refer the woman who is determined to be at risk for preterm birth or poor pregnancy outcome to the MCH's case management where follow up will continue. The Maternity Risk Screen form can be found on the DHCFP website at http://dhcfp.state.nv.us. Medicaid reimbursement continues to be a major challenge per conversations with providers. The Title V staff and our partners continue to offer information and support to private and public providers including billing and coding education for services that impact state objectives.

Child Health

Recent HEDIS report for Medicaid Managed Care shows significant improvement in rates of Early Periodic Screening Diagnosis Treatment (EPSDT) in our state. Community stakeholders have been leaders to increase awareness of families of the benefit available to them.

Participating managed care staff and physician associations have supported education and incentives to providers to comply with the AAP recommended schedules and age-appropriate screening.

Staff and community partners have been active to recruit primary care providers to take the well child online curriculum. The initiative is to promote comprehensive well child and EPSDT exams at http://www.brightfutures.org/wellchildnevada. Recent progress has been inclusion of the curriculum in a Nevada University residency program. Other partners are Family TIES and Nevada 211.

Nevada's Health Officer, Dr. Tracey Green has brought a group together to view other Bright Futures curriculum to address other childhood issues through provider education and training. Looking forward to a lifetime of health beginning as soon as possible, childhood obesity is a major focus of upcoming strategies for our MCH programs. MCH staff partner with schools, after school organizations, early childhood education and providers to educate and develop strategies for a health lifetime.

Community Input

The Bureau communicates with our communities consistently through many venues, and it is through these conversations and meetings that we are able to assess needs in an ongoing basis. The Nevada Advisory Council for CYSCHN conducted a survey that collected data from 100 families in rural counties, and NSHD Staff meet regularly with two state associations: Nevada Association of Superintendents & the Nevada Association of School Board Trustees. Discussions from these regular interactions have given rise to several pilot projects in school food service and in 2010 with a Kindergarten Survey. One project is the offering healthy snacks and implementing a salad bar. NSHD Staff also coordinate the State Fitness and Wellness Council, who is also interested in school health. It is in this milieu that the following priorities for 2010 from the MCH Needs Assessment were established. The needs assessment initial data collection and focus groups were convened in early 2010. Assessing and revising our direction will be based on our continued evaluation of needs. The data establishes our priorities and closely complement the HRSA MCHB goals and the MCH Advisory Boards recommendations. They will guide the Bureau's work in the coming years:

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.
2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.
4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.
5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.
6. Increase financial coverage and decrease financial gaps for health services among the MCH populations.
7. Decrease the incidence of domestic violence among women of child-bearing age.
8. Decrease the risk factors associated with obesity for children and women.
9. Decrease unintentional injuries among the MCH populations.

In late 2009 an MCH coalition was formed in southern Nevada, this coalition decided their initial priority area was prenatal access to care. Although newly formed the coalition have already appointed a chairperson and have developed priorities to address barriers to access to prenatal care. A prenatal workgroup was also formed from members of the MCH Advisory Board; the first activity was to address access to care issues. The workgroup agreed directing MCH focus to a population based service served a broader, fiscally responsible purpose. Another barrier identified was the length of time for pregnant women to become Medicaid eligible and have identified this issue as a priority. The coalitions in the north and south have set priorities and implemented activities. For the north a website for outreach and information was developed and the south convened a children's summit to promote and generate support.

Health Equity

The MCH program recognizes the impact of the changing demographics in the state, both from the increasing population and the changing race and ethnicity of its citizens. All MCH programs as do those in the Health Division work to address health disparities in all initiatives. These efforts are described throughout this document. They include the Maternal and Child Health Campaign, which serves women with no resources for prenatal care; those served are primarily Hispanic. In addition, MCH Campaign staff is working with a coalition of medical providers in southern Nevada which includes the Latin Chamber of Commerce to address disparities in accessing prenatal care. Most of those who answer the Information and Referral line are bi-lingual. The Bureau makes an effort to recruit bilingual staff. MCH Campaign media materials are in English and Spanish. Oral Health surveillance of Head Start children and children in the third grade find higher rates of decay in minority children; oral health initiatives work to address these inequities. The teen pregnancy prevention initiatives target the Hispanic populations as they have the highest rate of teen pregnancy. The WIC program is seeking to place clinics in areas frequented by Hispanics and African Americans, and has all its' materials in both English and Spanish. There are translators in all WIC clinics where necessary. CSHCN materials are in English and Spanish. The PSAP brochures are also in Spanish and English. The MCH Manager is working with the Office of Minority Health and local community based organizations to resurrect the African American initiative on reducing infant mortality and low birth weight.

With our State Birth Records Registry working many MCH programs can link and collect data for improvement in program development. With the assistance of the federal MCHB and state and community partners a project is under way to integrate cultural and linguistic competence into our MCH programs. The integration will be in stages and stage II continues in December 2010 with train the trainer workshop that integrates state partners, Health Division and MCH staff and provides tools and direction on integrating Cultural and Linguistic Competence into policy, values, principles and action.

Our MCH programs are collaborating with Women Infant and Children program, providing education and training to parents and staff on MCH health issues. This collaboration further develops our communication with our diverse populations and offers them our resources and services while building an improved health system of assessment and referral.

Health Care Reform

MCH staff and community partners have been on many teleconference calls and Health Division meetings with federal and state partners learning and information of healthcare reform issues as we are being made aware. Questions of pre-existing conditions and high risk pool coverage are of vital concern for children, families and those that serve the special health care needs population. MCH is keeping our partners informed of all available updates on coverage under health care reform.

Understanding that health care reform has the potential to change the way our programs assist our population and will affect our population in how they access healthcare is what drives our planning for the future. Our staff is committed to improving services, systems and outcomes for our MCH population in Nevada and we are planning in stages for the future. One of our partners is Medicaid and how MCH can assist with outreach and enrollment. One role MCH will play is in assisting with resolving any confusion the public has with health care reform and how it affects them, care coordination and navigation through a complex system can be a vital role for MCH. As we become more aware of where gaps lie in healthcare reform Nevada's MCH program stands ready to serve.

B. Agency Capacity

The Bureau works to leverage its resources to promote and protect the health of the MCH populations it serves including CYSHCN. It does this through partnering and collaborating with multiple agencies and programs, both government and private, across the state. Many of those efforts are described in this Section.

Program authority for Nevada's MCH and CSHCN programs are contained in Nevada Revised Statutes (NRS) and Nevada Administrative Codes (NAC) as follows:
* NRS 442.120-170, inclusive. Designates the department of human resources through the health division to "Cooperate with the duly constituted federal authorities in the administration of those parts of the Social Security Act which relate to maternal and child health services and the care and treatment of children with special health care needs".
* NRS 442.130. Designates DHR as the agency of the state to administer, through the SHD, a MCH program, and to advise the administration of those services included in the program that are not directly administered by it. "The purpose of such a program shall be to develop, extend and improve health services, and to provide for the development of demonstration services in needy areas for mothers and children".
* NRS 442.133. Establishes the Maternal and Child Health Advisory Board. The purpose of the Board is to advise the Administrator of the SHD concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of children.
* NRS 442.140. Authorizes a state plan for MCH.
* NRS 442.180-230. Authorizes the department (DHR) to "administer a program of service for children who have special health care needs or who suffering from conditions which lead to a handicap, and to supervise the administration of those services included in the program which are not administered directly by it."
* NRS 442.190. Authorizes a state plan for children with special health care needs.
* NRS 442.115. Authorizes the State Board of Health (also appointed by the Governor) to adopt regulations governing "examinations for the discovery of preventable inheritable disorders, including tests for the presence of sickle cell anemia". The follow-up for those whose examinations and tests "reveal the existence of such a condition" is described in this statute also. The newborn screening program is placed in the Bureau.
* NRS 442.320-330. Authorizes the establishment of a Birth Defects Registry
* NAC 442. Maternal and Child Health. Establishes regulations for the CSHCN program regarding eligibility, covered conditions and so forth. It establishes the protocol for the taking of blood

samples from infants for newborn screening, establishes fees for services of the Bureau of Early Intervention Services' Early Intervention Services, and the nurses of the Bureau of Community Health Services, and defines level of care of hospital neonatal units. It also establishes the provisions for the operation of the Bureau's Birth Defect Registry. /2010/ AB 136, creating statutory authority for the Oral Health Program and for a 13 member State Oral Health Advisory Committee, was passed during the 2009 legislative session. //2010//
Note: The 2005 Legislature changed the name of the Department of Human Resources to the Department of Health and Human Services. This change will occur in the coming year. For the purposes of this document, DHR will be used when referring to the Department.

All of the above statutes and regulations impact the operations of Nevada's MCH and CSHCN programs by giving state authority for the programs to the SHD and setting operating regulations into state law. This ensures the programs operate within legal boundaries established and monitored by the state. In addition to the authority for MCH, CSHCN, Newborn Screening and the Birth Defects Registry contained in NRS and NAC, the state budget process also places MCHB's Abstinence Education, SSDI, and Newborn Hearing grants, WIC, Primary Care Organization, the Center for Disease Control and Prevention's (CDC's) Oral Health, Rape Prevention and Injury Prevention grants and the Centers for Medicare and Medicaid Real Choice Systems Change grant within Bureau operations. In FY04 the MCHB funded Early Childhood Comprehensive Systems grant was added.

The Bureau seeks to work closely with state's public health community including the Clark County Health District (CCHD), Washoe County District Health Department (WCDHD) and Carson City Health Department to promote the health and well being of the MCH/CSHCN populations in those counties, as well as with the other Bureaus of the SHD. Title V funding supports adolescent health clinics in both Clark and Washoe Counties. Title V funding provides some support for Community Health Nursing in Nevada's rural and frontier counties.

The Bureau is home of a small program that is payor of last resort for the treatment of CSHCN. This program acts as a safety-net provider for eligible individuals who do not meet the eligibility requirements for Medicaid, Supplemental Security Income (SSI which includes Medicaid in Nevada), or Nevada Check Up (Nevada's S-CHIP program), and otherwise meet the eligibility requirements contained in NAC. For covered children the program will pay for specialty and subspecialty care, nutrition and primary care and reconstructive dental care if the child does not have insurance. CSHCN staff refer potential eligible families to Medicaid, SSI, and Nevada Check Up, and follow them until eligibility determination has been made. The Health Division data system has been revised and converted to new software that allows automated data matches with Newborn Screening, the Birth Defects Registry, Medicaid claims, Vital Statistics and Newborn Hearing Screening, and a variety of other state programs. This enables staff to better track what programs and/or initiatives are following the children, services received, etc. The monitoring of eligibility of children referred to Medicaid and Nevada Check Up is now accomplished on-line. Eligibility for the program is currently established at 250% of the Federal Poverty Level, with legal residency in the Nation and Nevada residency required.

The Bureau used to have a program that paid for prenatal care for eligible women. /2011/Redirecting focus to serve more prenatal women, MCH directs support at multiple sources of access for pregnant women, at these locations, each client is screened for social service needs, nutrition needs, domestic violence, substance abuse, and perinatal depression. //2011//These community, direct and enabling service providers screen all clients for social service, referring to various community agencies as needed. Early entry into prenatal care is particularly low among Hispanic women. All contracted agencies with the Bureau are to offer bilingual (English and Spanish) service, and have culturally appropriate materials. As part of the services provided by the community based provider the infant born to the covered mother is followed to age one. A medical home will be established for the infant when this service ends on their first birthday. In FY 07, a budget enhancement to expand the above stated services was submitted for inclusion in the Governor's budget; however, this enhancement was not included in

the Governor's final budget. We will continue to research and identify other resources that may be used to enhance our Maternal and Child Health Campaign.

Another part of the MCH Campaign is a toll free bilingual (English and Spanish) Information and Referral Line (IRL) that serves as a referral source for pregnancy care statewide. It is also provides information for families in need of pediatric care, with referrals to Nevada Check Up, Medicaid, and pediatric providers a service offered through the IRL. Campaign pediatric providers are in Clark and Washoe Counties, and in the rural communities of Armagosa, Austin, Beatty, Elko, Eureka, Gerlach, Hawthorne, Pahrump and Carson City. This number is 1-800-429-2669 (the same number used for Baby Your Baby). The IRL has been a primary component for signing up women, infants and children for Medicaid and Nevada Check Up as well as referring them and their families to other services such as WIC, immunizations, adoption, substance abuse treatment, a source for dental care, etc. All who call are queried regarding their insurance status. If they do not have or have concerns about it, staff will refer them to Medicaid and/or Nevada Check Up and other resources such as the members of GBPCA and the Bureau's MCH Campaign providers and CSHCN program. A third part of the MCH Campaign is an outreach campaign that includes a mass-media campaign, again in both English and Spanish, that educates the public about pregnancy and other related matters. The Bureau has contracted with the Nevada Broadcaster's Association to air both radio and television announcements about the importance of early and continuous prenatal care, information about Medicaid and Nevada Check Up, proper nutrition during pregnancy, and where care may be obtained. This outreach campaign is funded by a contract with DHCFP, Medicaid. For each dollar that the Bureau spends on public education, Medicaid will match it./2011/In late 2009 the service was transfereed to our sttewide information and referral line that now has resources and information for perinatal services./12011//

The Bureau also now has a toll-free IRL for CSHCN. This new phone number is currently being marketed through a media campaign. It refers callers to services available in the state for CSHCN and their families. This number is 1-866-254-3964.

The Bureau is linked electronically with Medicaid and Nevada Check Up eligibility records in order to check eligibility and prevent duplications. The CSHCN Program does not serve those eligible for Medicaid or Nevada Check Up (unless it is a service such as specialty foods that Medicaid or Nevada Check Up do not pay for). This is possible through NRS, which allows sharing of information between Divisions of the Department of Human Resources and ensures confidentiality of those communications.

The Bureau has a web page where a description of Bureau programs and initiatives may be found and links to web pages either specific to the Bureau such as Oral Health and WIC or relative to MCH such as the Interactive Data Base of the Center for Health Data and Research that is partially supported by the SSDI grant. The Bureau web page is located at http://health2k.state.nv.us/bfhs/. Program web pages can be accessed through the Bureau's main web page. The Prenatal web page contains information on how to have a healthy pregnancy, infant care, well child issues, teen pregnancy issues, and many other topics related to maternal and child health. It is one of the most popular web pages on the SHD web-page, receiving several hundred hits a week. A new CSHCN web page was launched in January 2005. It contains links to Medicaid, Nevada Check Up, Food Stamps, SSI, and other programs that might be useful for CSHCN and their families. It is currently being marketed through a media campaign. /2008/ The SHD web page address has changed to http://health.nv.gov. To reach the Bureau's web page the reader has to start at the SHD web page, and then select the Bureau. From there selection can be made of the program web page. The SHD web page no longer has page selection web addresses. //2008//

The Bureau continually works to partner with Medicaid in promoting the health and well-being of Medicaid pregnant women and then their infants. Through contacts between the two agencies and interaction before the Maternal and Child Health Advisory Board (MCHAB) MCH is able to

bring concerns about both Medicaid and Nevada Check Up to the attention of the regulatory agency and see them addressed as much as possible. The Bureau continues to look for ways to perform outreach for Nevada Check Up and Medicaid including the contract for the MCH Campaign. Referrals to Nevada Check Up and Medicaid are made through the CSHCN Program, the MCH campaign and WIC, and in FY 06 through the Real Choice Systems Change pilot projects discussed below.

The Bureau continues to work closely with the University of Nevada School of Medicine (UNSOM). Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Cleft/Craniofacial clinics in Reno and Las Vegas. The Bureau Chief and a UNSOM Geneticist are currently working out the details of a Fetal Alcohol Syndrome multi-disciplinary clinic that will first be held in Las Vegas. A vision care clinic also in Las Vegas at a Early Intervention site has recently been proposed and is under consideration.

The Bureau is working very closely with the new Office of Disability Services and Community Based Services which are in DHR Director's office. The Office of Disability Services is working closely with the Real Choice Systems Change project discussed below, particularly on the area of transition of CSHCN to adulthood. It was also the lead on a "211" line for one-stop referrals proposed during the current legislative session and worked with the Bureau to ensure the Bureau's hot lines were appropriately included. This bill did not make it out of session; it was however reintroduced in an omnibus bill that included $200,000 to implement a 211 line. A committee of representatives from the various DHR Divisions including Health's MCH is currently meeting to begin the development of the line.

The Department of Human Resources is the recipient of a three-year Centers for Medicare and Medicaid Services (CMS) $1,385,000 grant to build systems of care for Children with Special Health Care Needs. This is a "Real Choice Systems Change" (RCSC) grant. This DHR grant was placed in the Bureau for implementation. It experienced a delay in implementation which will lead to a fourth year into FFY 06. Its components are a CSHCN Advisory Committee, a CSHCN Needs Assessment, a web page, and 3 pilot projects implementing the findings of the Needs Assessment for CSHCN systems development. The media campaign is currently underway (and is the one marketing the CSHCN web site and IRL.) The Needs Assessment was completed in January 2005 and the Advisory Committee appointed; several meetings have been held. The Advisory Committee has had a subsequent meeting to review the findings of the Needs Assessment and is overseeing the pilot projects that the grant calls for based on the findings of the Needs Assessment. The CSHCN Needs Assessment is a complete in-depth assessment of CSHCN in Nevada to provide a better understanding of the nature and magnitude of challenges facing CSHCN ages birth to 22 and their families in Nevada (e.g., the level of need, amount of services available, amount of services required, service gaps, cultural issues, service duplications, etc.). The data generated by this study will help address CSHCN systems development. Three pilot projects, northern urban, southern urban, and rural, are in the process of being developed and implemented based on the findings of the Needs Assessment. The data generated from the needs assessment will also be used to develop public policy initiatives and demonstration projects to ensure coordinated, family-focused, and community-integrated systems of care for all of Nevada's Children with Special Health Care Needs. This includes family partnership in system planning and service selection, effective supports for CSHCN transitioning to adult life, and better-coordinated care throughout childhood and into young adulthood. This is the piece that is being coordinated with the Office of Disability Services.

The PCDC partners very closely with the Great Basin Primary Care Association and its members to promote access to primary care for all Nevadans including pregnant women, infants, children and adolescents, and CSHCN. In many rural parts of the state as well as in Washoe and Clark Counties GBPCA members are the only providers available for primary care including infant well-child and other care particularly for low income individuals. In 2005 one of its members, Nevada Health Centers, also became a WIC provider in Southern Nevada. In addition, the MCH supported Community Health Nurses of the BCH provide well-child services for infants in the rural

counties.

MCH will continue to support Adolescent Clinics in Reno and Las Vegas. These are provided under contract with Washoe County District Health Department (WCDHD) and the Huntridge Teen Clinic in Las Vegas. The Child and Adolescent Health Coordinator will work with the Adolescent Clinics in the coming year to assure they continue to address identified needs. /2010/ The contracts with Washoe County District Health Department (WCDHD) and the Huntridge Teen Clinic in Las Vegas were both discontinued in 2009. //2010//
The MCH Chief serves on DHR's Child Care Advisory Committee, representing the SHD to promote health concerns. The Child Care Steering Committee includes representatives of Health, Welfare, Dept. of Education, Nevada's Community Colleges, University of Nevada, Head Start, Welfare contractors, Consumers, Family to Family Connection, etc. It is charged with advising the Department of Human Resources and the Governor on improving quality and availability of child care for Nevada's children, particularly those services provided to TANF recipients and clients who are receiving transition services from TANF. The MCH Chief is one of 4 state employees on this Committee.

The MCH Chief participates in the Title V-B Steering committee for Family Preservation and Support. The MCH Chief will continue work to ensure MCH concerns are addressed in any changes to Nevada's Title IV-B program. Through the DHR Child Care Advisory Committee, the MCH Chief continues to promote the inclusion of training for care of CSHCN in all training initiatives. The inclusion of CSHCN in all publicly funded child care including those sites receiving assistance with development and training from Welfare is also promoted.

The Bureau continues to work with the Welfare Division for the training of Child Health Care Consultants. The federal grant supporting this initiative which was held by the University of Nevada Reno has ended. Staff is currently contracting with the Area Health Education Center of Southern Nevada, using the Early Childhood Comprehensive Systems (ECCS) grant, to further develop and sustain a Child Health Care Consultant Network in Nevada. In conjunction with this contract, the ECCS program has initiated the training of three trainers for Nevada's Child Health Care Consultant Network. Throughout this next year, the program will be identifying various health care professionals including public health nurses, mental health professionals, developmental specialists, and others to serve as Child Health Care Consultants. In addition, ECCS staff is working with staff from child care licensing agencies to explore the inclusion of Child Health Care Consultants in current licensing policies. Through these efforts, we are working to develop an effective and sustained Child Health Care Consultant Network throughout Nevada./2010/ In early 2009 the ECCS grant was moved to the Administrative Office of the Department of Health and Human Services under Head Start State Collaborative Office. The MCH Manager and Title V staff continues to be fundamental partners in building a statewide network of CCHC's. Through collaboration a more diverse purposeful group of partners have joined this initiative providing support and expertise. Recently the ECCS grant was awarded to the HSSCO for another 3 years. Additionally Title V staff collaborated in submission of a proposal for "Project LAUNCH" to SAMSHA and are awaiting outcome. The pilot CCHC project in Clark County is coming to an end and data is collected and will be analyzed and released to our stakeholders soon. //2010//

Nevada Revised Statutes state that all child care providers must attend a class that covers preventing and recognizing illnesses. In the past, this class has been held only in Clark and Washoe Counties on a regular basis, and Bureau personnel have given the class when possible in the rural counties and parts of Clark County. Most child care providers have not been able to receive this class due to access issues. However, now all community health nurses in the rural counties have been trained by Bureau personnel to teach the "Prevention and Recognition of Illnesses in the Child Care Setting" class. In addition, Southern Nevada Area Health Education Center (AHEC) personnel located in Clark County are being taught the curriculum so that they can service the outlying areas of Clark County. In the near future, this class will be available state-wide and all child care providers should be able to access this class easily.

The 2005 Legislature approved the establishment of an Office of Minority Health effective July 1, 2005, in the DHR Director's office. This has been a goal of the Department for many years. The purposes of the Office are to improve the quality health care services for members of minority groups; increase access to health care services for members of minority groups; and disseminate information to and educate the public on matters concerning health care issues of interest to minority groups. The Bureau will partner with the new office to address minority health and health disparities in all its efforts.

The Bureau works with all known parent and advocacy groups such as Parents Encouraging Parents (PEP), Family Voices, "Nevada Partners in Policymaking" and the "Nevada Dual Sensory Impairment Project", to discuss available programs and accessing services within the community. Activities have included meetings and panel discussions with consumers in both Reno and Las Vegas to discuss the scope of services covered by Title V programs, as well as developing linkages with other agencies such as Medicaid, Nevada Check Up, Vocational Rehabilitation, Shriner's, and the Department of Education, for access to, and coordination of, services. The meetings included a cross section of consumers, many of whom are adults with disabilities, as well as the parents and foster parents, of children who have a variety of disabilities and needs. This also provided an opportunity to dialog with members of the community and the staff of multiple community agencies. As a result, there is increased communication within a growing network of service organizations and consumers. Family Voices was very prominent in assuring parents of CSHCN input into the MCH Needs Assessment, and will assist with implementing its findings. The CSHCN program now includes information about Family Voices in all its communications with families. All of these agencies and consumers are involved in the development of the Real Systems Change initiative. The Family Voices Director is developing the RCSC media campaign.

/2007/ There has been no change to NRS and NAC since last year or to the information reported above. The Department of Human Resource officially has become the Department of Health and Human Services (DHHS).

The vision care clinic went on hold when the staff proposing it quit. It is now being revisited by staff to see if the resources are still there and if new partners that have since been identified are able to help.

The DHHS Title IV-B Family Preservation and Support Steering Committee is no longer meeting. Its activities have been absorbed by other activities going on in the state including the Child Death Review initiative discussed in IV A Background and Overview.

The DHHS Child Care Committee has not met.

The Office of Minority Health has been established; it is based in Las Vegas. The Bureau's Bureau Chief has been in contact with the new Minority Health Director and enlisted his assistance in the expansion of the MCH Campaign to address African American birth outcomes discussed in the Annual Plan for National Performance Measures (NPM) 15, 17 and 18 and State Performance Measure (SPM) 11. He is building support in the Las Vegas African American community for this enhancement, which will be presented to the 2007 Legislature.

The CSHCN program's eligibility line was transformed into a statewide toll-free CSHCN helpline offering assistance to more families than before. The Health Program Manager from the grant project will continue work for the Bureau of Family Health Services (Title V) programs. Community-based service providers affiliated with the grant project may be considered for contract work.

There has been an attempt to include more bi-lingual members on the Nevada Advisory Council for CSHCN and producing outreach materials in English and Spanish. The website translation is

in a pending status (rudimentary translation available, improved translation in the works). The Native American temporary worker who has been successful with Native American outreach has future Maternal and Child Health funding.

The RCSC Project has segued into a CSHCN systems development project that will combine all the CSHCN systems development efforts under one umbrella. This project is now under an overall CSHCN Coordinator who will manage it and the specialty clinics, BDR, newborn screening, newborn hearing screening, and any other components of the CSHCN system. Through the systems development activities a training for those with potential responsibility for utilization of EPSDT screening will be offered in the fall of 2006. //2007//

/2008/ There hasn't been much change since last year, including no change to NRS or NAC. The MCH Campaign to address African American birth outcomes was not selected to be included in the Governor's budget due to the tightness of the state's budget. The MCH Manager has started conversations with African American community based organizations to lay the groundwork for another effort in the 2009 Legislative session.

A review by the National Center for Newborn Screening lead to the conclusion that in addition to the metabolic clinics the Bureau supports the Bureau needs to add Endocrine and Hemoglobinopathy Clinics also to ensure appropriate follow-up for newborn screening. This is added to the need for a vision clinic. While there is no funding in the next biennium budget for a vision clinic per se, the Bureau is having to rebid its newborn screening contract as this must be done every 4 years. In consultation with SHD Administration it has been determined that when the anticipated fee increase is requested of the State Board of Health, it will include funding for Hemoglobinopathy and Endocrinology clinics as they are part of newborn screening. It is hoped that these clinics will be developed in the coming year.

The name of the Department has officially changed to the Department of Health and Human Services. All phone and fax numbers have remained the same.

The 2-1-1 line is now operational statewide. In addition it received an appropriation of state general fund from the 2007 legislature so will continue to function at least through the 2008-2009 biennium.

The DHHS Child Care Advisory Committee has resumed meeting. It is working in close collaboration with the Bureau's Early Childhood Systems Development initiative and continues to advise the Welfare Division on the policies and procedures for its child care system.

The Health Division is revitalizing the Child Care Health Consultants. An update is given in III E.

The EPSDT meeting was held. As a result there are currently 4 Bureau supported work groups working on various aspects of EPSDT outreach: automatic newborn enrollment; cross system linkages to EPSDT (data); Tribal, FQHC, Local Health Department and MCO coordination; and parent support and education. The work groups include Bureau staff, Medicaid staff and others such as MCO representatives.

//2008//

/2009/ There was no change to the NRS in the past year; the NAC was changed to increase the newborn screening fee from $60.00 to $71.00 per birth. The increased funding allowed the addition of Cystic Fibrosis screening to the screening panel effective May 1, 2008. The Bureau is in the process of developing the Endocrine and Hemoglobinopathy clinics referenced last year and will implement them in the coming year.

As noted in III A the state is undergoing a fairly significant budget crisis. In the first round of budget cuts this year the Bureau lost the funding for the expansion of the fetal alcohol spectrum

disorder (FASD) clinics. A settlement negotiated by the State Attorney General over the acquisition of Sierra Health Services, Inc. by United Health Services included restoring the funding to the clinics. As this is written the funding has not yet become available but plans for the clinics continue with the hope they will be implemented in September 2008. This is one time funding.

The DHHS Child Care Advisory Committee is once again not meeting. Its continuation is in jeopardy as other efforts are taking its place, including the development of an Early Childhood Advisory Committee.

The Bureau Chief is working with the Manager of the Office of Minority Health to seek ways to implement the African American birth outcomes initiative that was not approved during the last session. It is very doubtful that such enhancements will be allowed in the coming session and the two programs are looking for ways to involve community members including church communities to address the issue.

Early Periodic Screening, Detection and Treatment (EPSDT) has continued its Title V and Title XIX partnership and has had the following successes:
o getting newborns enrolled in Medicaid/Nevada Check Up before birth
o Resuming notifying families of the EPSDT benefit at enrollment. This had been dropped due to staff turnover.
o Strong MCO involvement in workgroups
o Restoration of a form providers are used to bill for EPSDT
o Networking with community-based organizations including Family TIES, Head Start and other grass-roots organizations to provide notification to parents of the EPSDT benefit.
o Developing a family friendly brochure
Developing the EPSDT toolkit: Website -- www.health.nv.gov
o Ongoing workgroup meetings, such as the Parent Support and Education workgroup. The Auto Newborn enrollment is the only one that is not continuing as what is left to do is within two state agencies.

The continued goal of the State Health Division and Nevada Medicaid is to increase the number of eligible children receiving screening, diagnosis, and necessary treatment services through EPSDT thereby also increasing the number of children appropriately immunized.

The Nevada State Health Division is taking a much-needed look at its role in public health and how it conducts business. Richard Whitley, the new HD Administrator, has vowed that HD will do business differently, with the Bureau of Family Health Services (BFHS) in the lead. Staff met in a planning session to discuss MCH staffs' core competencies, identify community competencies and create new MCH Block grant State performance measures and goals. Staff divided themselves according to MCH Block Grant 2009 objectives.

This planning process was invaluable to staff; educating, engaging and empowering them in an unprecedented way. Knowing that the 2010 Needs Assessment is coming up the Health Division is now looking at how to functionally/structurally organize to best situate staff to accomplish new performance measures which based on current data will probably be part of the measures proposed for the next five year period. It is an exciting and dynamic time. BCFCW, through the MCH Block Grant, is looking to grow and support local efforts related to the national and state performance measures outlined within the MCHBG. The primary goal is to use MCH money to grow local initiatives that are over time locally-owned and sustained, and then remove the MCH Anyone involved in change management knows that this process takes time. Thus, this year is a bridge of cultural change whereby the HD is obligated to this change process with a commitment to our partners to add to their community capacity, in the way our partners envision. The Health Division looks forward to discussing with local health districts and rural community health nurses about their perceived role and the role of the HD. The HD hopes that it is a dynamic dialogue that tells us what the needs are, how to fill them, which agency is leading which aspect of the project,

and ultimately together, to improve the health of women and children in Nevada. Activities that are projected to be accomplished in FY 09 are listed in the activities for National and State Performance Measures.
//2009//
//2010//
//2011//

C. Organizational Structure

/2010/ Nevada's Executive Government is set up with the elected Governor as the Head of State. The current Governor Jim Gibbons, is in his first four-year term. //2010// Under the Governor are the various Departments that along with Boards and Commissions that make up the Executive Branch, including Human Resources, Employment, Rehabilitation and Training, Information Technology, Motor Vehicles, Public Safety, Conservation and Natural Resources, Cultural Affairs, Administration, Personnel, Agriculture, and Business and Industry. The Legislative Branch includes the Senate and Assembly, the Legislative Counsel Bureau and Legislative Committees. The Judicial Branch includes the court system, commissions and the State Board of Pardons. An org chart of Nevada State Government may be found at http://www.leg.state.nv.us/lcb/research/StateOrgChart.pdf.

/2010/ The state public health agency, the State Health Division (SHD), is in the Department of Health and Human Services (DHHS). DHHS also includes the state mental health agency, the Division of Mental Health/Developmental Services(MH/DS); the social services/child welfare agency, the Division of Child and Family Services; Aging; the Medicaid and Nevada Check Up agency, the Division of Health Care Financing and Policy(DHCFP); and the TANF and Child Care Block Grant agency, Welfare. Mike Willden is the Director of DHHS. The org chart for DHHS //2010// may be found at http://hr.state.nv.us/Documents/DHR_904.pdf. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives. /2007/ As previously noted DHR is now the Department of Health and Human Services, DHHS. //2007//

As noted in III.B, Agency Capacity, Nevada Revised Statute 442 designates the Department of Health and Human Services (DHHS) through the State Health Division to administer those parts of the Social Security Act which relate to Maternal and Child Health and the care and treatment of Children with Special Health Care Needs. Within the SHD the MCH and CYSHCN programs are in the Bureau of Child, Family, and Community Wellness.

/2010/ The SHD contains 5 Bureaus, each headed by a Bureau Chief. In addition to the Bureau of Child, Family, and Community Wellness are are: Licensure and Certification (BLC), Health Planning and Vital Statistics (BHP&VS), Early Intervention Services (BEIS), Health Protection Services (BHS), and Substance Abuse, Prevention and Treatment (SAPTA). Richard Whitley, MA is the Administrator of the SHD, hired in his place in January 2008. Mr. Whitley was previously Deputy Administrator in the State Health Division. Mr. Whitley received his baccalaureate degree from Willamette University in Oregon, and a Master of Science in Counseling Psychology from Western Oregon State College.

The new Deputy Administrator is Mary Wherry, RN, MS. Ms. Wherry became Deputy Administrator in May 2008. Previously she served as Deputy Administrator of the Division of Health Care and Financing where she administered the Medicaid and Nevada Check Up operations. Ms. Wherry holds a baccalaureate degree in nursing from San Jose State University in California and Master of Science degrees in Psychiatric Mental Health Nursing and Health Policy with a Poly Science Certificate from the University of Maryland. /2011/Ms. Marla McDade William is our new Deputy Administrator since May 2010. Ms. Williams, holds a baccalaureate degree in nursing and a masters in public administration. Ms. William previously lead the Bureau of Health Care and Quality Compliance. //2011//

The State Health Officer is Mary Guinan MD & PhD. Dr. Guinan previously served as the health

Officer from 1998 to 2002. She currently is Founding Dean of the University of Nevada Las Vegas School of Public Health. Prior to coming to Nevada Dr. Guinan worked at the Centers for Disease Control and Prevention in various scientific and administrative positions for over 20 years. She is certified by the American Board of Internal Medicine, the subspecialty Board of Infectious Diseases and the American Board of Preventive Medicine and Public Health.

The SHD organization chart is attached at III B, Agency Capacity.

The Bureau works very closely with all five of the other Bureaus. It provides funding for Community Health Nurses in Frontier and Rural Area and partners with chronic disease initiatives. //2010//The Center for Health Data and Research in the BHP&VS works with the SSDI grant and produces the data for the MCH Block Grant application and oversees the MCH Needs Assessment process. BADA works with the Bureau on its Perinatal Substance Abuse Prevention initiative, particularly focusing on adolescents. A bill in the 2005 Legislature will move BADA to MH/DS; even should this move occur the Bureau and BADA will continue to collaborate. While the Bureau's Oral Health Unit has the fluoride initiative, BHP has the engineers that monitor the water systems. The Bureau works with BLC on emergency medical services and on Newborn Intensive Care Unit regulations, which they regulate. Finally, the BEIS is collocated with the Bureau and works closely with the CSHCN program and other Bureau initiatives. Title V funds support the BEIS services. The Bureau also supports the multi-disciplinary specialty clinics held in BEIS facilities. The Bureau org chart is attached.

The Bureau of Family Health Services under the SHD Administration is responsible for Title V MCH Block Grant oversight, management and reporting. The Bureau has many programs and initiatives that all go to promote the health and well being of Nevada's families. Judith Wright is the Bureau Chief and MCH Director. ?

Nevada's MCH Program is advised by a Maternal and Child Health Advisory Board (MCHAB). The MCHAB was first established through an executive order in 1989, and then was established in statute in 1991 by NRS 442.133. It is comprised of 9 individuals appointed by the Governor from a list provided by the SHD Administrator to two year terms, and two legislators appointed by the Legislative Counsel. Its composition represents public health, providers, legislators and a consumer who always represents CSHCN. Per NRS the MCHAB is advisory to the Administrator of the SHD. They meet 4 to 6 times a year, alternating between Reno and Las Vegas, and more frequently now by videoconference. They respond quickly to issues as they come up and have testified before the Legislature on bills of concern to the Department. They produce a bi-annual report includes a report of their activities for the biennium and recommendations for the coming biennium. This report is placed on the Bureau's web page and some hard copies distributed at the Legislature. The 2005 report is attached to I.E, Public Input, as is noted there. The MCHAB is staffed by the MCH Bureau Chief. Under NRS they are charged to advise the Administration of the SHD "concerning perinatal care to enhance the survivability and health of infants and mothers, and concerning programs to improve the health of preschool children to achieve the following objectives:

1. Ensuring the availability and accessibility of primary care health services;

2. Reducing the rate of infant mortality;

3. Reducing the incidence of preventable diseases and handicapping conditions among children;

4. Identifying the most effective methods of preventing fetal alcohol syndrome and collecting information relating to the incidence of fetal alcohol syndrome in this state;

5. Preventing the consumption of alcohol by women during pregnancy;

6. Reducing the need for inpatient and long-term care services;

7. Increasing the number of children who are appropriately immunized against disease;

8. Increasing the number of children from low-income families who are receiving assessments of their health;

9. Ensuring that services to follow-up assessments are available, accessible and affordable to children identified as in need of those services; and

10. Assisting the Health Division in developing a program of public education that is required pursuant to NRS 442.385, including, without limitation, preparing and obtaining information relating to fetal alcohol syndrome (FAS);

11. Assisting the University of Nevada School of Medicine in reviewing, amending and distributing (FAS) guidelines it is required to develop pursuant to NRS 442.390; and

12. Promoting the health of infants and mothers by ensuring the availability and accessibility of affordable perinatal services."

The State Board of Health (SBOH) is a regulatory body that is staffed by the SHD Administrator. As MCH is not regulatory it does not have much activity before the SBOH, but it does go before them to set fees for Newborn Screening and other matters that are contained in the NRS for the Bureau. The Newborn Screening fee increase was approved by the SBOH in September 2003. In 2004 the Bureau partnered with BLC to update the NICU regulations, which were approved by the SBOH on June 25, 2004.

The CSHCN Program has already been described in III.B. Agency Capacity. It pays for treatment for eligible children. The CSHCN program includes Newborn Screening, Newborn Hearing Screening, and the Birth Defects Registry. These three programs are all required by NRS. The Newborn Screening and Birth Defects Registry programs and the program's supervisor are funded by newborn screening fee revenue. Newborn Hearing is funded by HRSA (this grant will end in 2006 and another has recently been approved). CSHCN also includes the Real Choice Systems Change Grant that is funded by CMS.

The MCH Perinatal and Women's Health program includes the Perinatal Substance Abuse Prevention (PSAP)program, the MCH Campaign, and Domestic Violence, Injury and Rape Prevention programs. Injury and Rape Prevention are funded by CDC. PSAP is funded by state general fund. The supervisor of the unit is funded by Title V, the MCH Block Grant.

The MCH Perinatal and Women's Health and CSHCN Programs are headed by Health Program Specialist IIs.

The Child and Adolescent Health Program addresses teen pregnancy prevention and other initiatives to promote the health and well-being of Nevada's children and adolescents. It includes the Abstinence Only grant now managed by the Administration for Children and Families. It also includes the MCHB Early Childhood Systems Development grant, and with the additional funding from the MCH Block Grant the state received has a component for Early Childhood systems development for ages 6-10. It is headed by a Health Program Specialist II who is funded by Title V, the MCH Block Grant.

The Oral Health Unit includes a statewide sealant initiative, a fluoride initiative, Prevent Abuse and Neglect through Dental Awareness (P.A.N.D.A.), Early Childhood Caries prevention, Oral Health Surveillance, and is developing an oral health curriculum for primary and secondary education. It is funded by CDC and MCH Block Grant. The Oral Health Unit is headed by a Health Program Specialist II who is funded by the CDC grant. /2010/ The oral health curriculum project

has been discontinued. //2010//
The WIC Program has clinics statewide. It is currently serving approximately 46,000 participants a month. It is funded by USDA and rebates. It is headed by a Health Program Manager II who is funded by the WIC grant. WIC expects to reach 60,000 by the end of the next biennium (FY2006-FY2007.

The Primary Care Development Center works to promote access to primary care statewide. It has the Primary Care grant from the Bureau of Primary Health Care, SEARCH from the Bureau of Health Professions and the HRSA/MCHB funded SSDI program. It is headed by a Health Resource Analyst III who is funded by the Primary Care grant.

Specific staff of the Bureau are listed in III D. Other (MCH) Capacity.

Title V funding is also placed as previously mentioned in the Community Health Nursing budget and in Early Intervention Services. Both programs work with the Bureau and provide the reporting required by the block grant. The MCH Bureau Chief assures the funding is being spent in accordance with federal regulation.

//2010//

The NV Health Division saw a much-needed re-organization occur in two of its Bureaus. The Bureau of Community Health merged with the Bureau of Family Health Services (many MCH Staff) to become the Bureau of Child, Family and Community Wellness. This is a strategic move to emphasize integrated programming among MCH and Chronic Disease activities. Please see attached organizational chart for details. Maria Canfield is the Bureau Chief and MCH Director, while Debra Wagler is the MCH Manager. The MCH Staff were empowered to completely change how the MCH Block grant funds and initiatives were executed in Nevada. Similarly, MCH Staff are re-engaging the MCH Advisory Board members in their roles: including monitoring, policy setting, and advocacy responsibilities. There has also been a much-needed change in Board member representatives. The MCHAB chose four priority areas for its focus in 2010: dental health sealants, immunizations, mental health and prenatal care/access. MCH staff plan to support all interests and initiatives.
An attachment is included in this section.

D. Other MCH Capacity

Nevada's MCH/CYSHCN programs, located in the Bureau, are managed through its main office in Carson City, Nevada. Staff who are located in the Carson City and Las Vegas offices are listed in the attached table along with CVs of program managers.

Deborah A. Harris serves as our MCH Director. Ms. Harris has extensive experience in program management and facilitation. She has worked for over 15 years in state service and comes to MCH in Febraury 2010. Ms. Harris experience in human resources for public an private entities and has developed and conducted management training in conjunction with needs assessment. Ms. Harris has facilitated strategic problem identification and has extensive experience in mediation, negotiation and conflict resolution in management. Ms. Harris worked in reorganization and restructuring efforts and has managed health and wellness outreach programs for private and public entities. Ms. Harris has a bacclaureate degree in communication studies from the University of California and a Masters degreee in organization management from the University of Phoenix in Reno, Nevada. Ms Harris has completed work as a Publlic Manager certification. Her past exprience is with the Nevada State Legislative Counsel Bureau as a Senate attache with the committee on government affairs.

Deborah Aquino manages the Title V/Maternal and Child Health (MCH) program within the

Bureau of Child, Family and Community Wellness in the Nevada State Health Division. She provides oversight, development and evaluation of the MCH Block Grant and the MCH five-year needs assessment process. Ms. Aquino works cooperatively with other staff of the Division, other agencies and public and private providers to promote MCH services in the state, to identify health needs, issues and gaps in service and develop recommendations to program services. She has extensive experience in health program coordination and evaluation for the Nevada State Health Division, as well as experience managing and team building in the private sector as a former banking manager and in her former roles in the non-profit sector and local government. This experience is useful in managing the MCH program toward building comprehensive, collaboratively-built, community-based systems of care for preventive and primary care services for Nevada's families ensuring that women, infants, children, adolescents, and their families, including children with special health care needs, have access to quality health care.

Ms. JoAnne Malay R.N. M.P.H. manages the Women and Children's Wellness section which includes the Nevada Center for Genetic and Inheritable Disorders program which houses Newborn Screening, Newborn Hearing and genetics. Additionally the EWECW includes the Women's Health Connection, breast and cervical screening program, Perinatal Substance Abuse Prevention, the MCH program and the Autism Training and Technical Center recently joined our team. The Women and Children's Wellness section envisions all women and children have an equal opportunity to obtain their maximum potential through our programs resources and supports. Ms. Malay serves as the CYSHCN Director. The performance measures we focus on include but are not limited to: NPM 1-7, 12, 13, 15, 17and 18. SPM 1, 6, 11, and 13.

Muriel Kronowitz, M.A., LPC, currently holds the position of the Perinatal Substance Abuse Prevention (PSAP) coordinator for the Nevada State Health Division. She has more than 25 years of experience developing, implementing and coordinating cutting edge pilot programs in the field of mental health and substance abuse. Some of her accomplishments include coordinating the opening of the only therapeutic family court in Alaska that addressed FASD, creating and implementing a pilot FASD project at the only women's correctional facility in Anchorage and was the first clinical director for the only residential treatment program for pregnant women and their children in Alaska. Prior to returning to public service she was the clinical director for a private mental health and substance abuse agency.

Melissa, RDH is currently responsible for the Nevada Early Hearing Detection and Intervention (EHDI) Program. Job duties include working with both programs to provide assurance of screening, follow-up and assurance of intervention. Additional job duties include development of both the EHDI Programs through collaboration with state hospitals, healthcare providers and non-profit organizations statewide.

Our Newborn Screening Program Manager position is currently vacant.

Lori Cofano, is a graduate of the University of Southern California School of Dentistry in Los Angeles, CA and holds a Bachelor of Science in Dental Hygiene. She practiced clinical dental hygiene for 19 years prior to joining the Oral Health Program. She has been with the Oral Health Program for over eight years as the Fluoridation Specialist and Oral Health Screening Coordinator. Currently she is the acting Oral Health Program Manager. In her capacity as Oral Health Screening Coordinator she has used the Basic Screening Survey to screen Head Start children, third grade students, and elderly in assisted living facilities. She has developed screening materials and reports that have been used by many other states. She was asked to present information on the Basic Screening Survey at the National Oral Health Conference in 2007. In 2008, she was asked to assist with the Association of State and Territorial Dental Directors (ASTDD) Basic Screening Survey training materials. The actual training DVD was filmed in Nevada using a Head Start location and a Carson City elementary school as well as several Oral Health Program contacts as actors. She has maintained an excellent working relationship with the Southern Nevada Water Authority and the City of Henderson water treatment staff in Clark County. These are the only facilities in the state that optimally fluoridate community

water sources. The Centers for Disease Control and Prevention (CDC) and the ASTDD have honored the water treatment facilities with a State Fluoridation Quality Award for the past six years. The award is based on monthly data sent to the Fluoridation Specialist and entered into the CDC Water Fluoridation Reporting System. She is currently working with water treatment staff to create an in-state water fluoridation training course. As the acting Oral Health Program Manager she participates in the six regional oral health coalitions and the statewide Oral Health Advisory Committee.

Randall Figurski, Manager of the MCH Autism Training and Technical Assistance Center, has a Master of Science in Speech-Language Pathology from the School of Medicine, University of Nevada, Reno. Mr. Figurski was a clinical instructor at UNR's School of Medicine in the 1990s where he taught undergraduate and graduate courses in language development and communication disorders. He was the Director of the Scottish Rite Language Disorders Clinic at UNR for three years before moving to the Nevada State Health Division. He is a former President of the Nevada Speech and Hearing Association, the State's professional association of audiologists and speech pathologists. Mr. Figurski has published scholarly articles in peer-reviewed professional publications related to communication disorders in children and adults and has presented at numerous state and national communication disorders conferences. For the past two years, Mr. Figurski has managed the Nevada Health Division's Autism Training and Technical Assistance Center, which is charged with building a professional workforce in Nevada communities and neighborhoods for the early identification and treatment of young children with autism and related disorders. He is an executive board member of Nevada's nonprofit Autism Coalition of Nevada, which represents community parent support and advocacy organizations from across the State. Since the early 1990s, he has consulted with 11 of Nevada's 17 independent school districts to diagnose and assess children with autism spectrum disorders. He has delivered many seminars on screening, evaluation and treatment of communication disorders to special educators, psychologists, occupational therapists and speech-language pathologists working in public and non-public agencies and organizations. Over the years, Mr. Figurski has served more than 300 families living with autism whose children ranged from 18 months to 18 years of age.

Kelly Y. Langdon, Statewide Breastfeeding Coordinator, has her Masters Degree in Public Health and has worked in the public health field for nine years. Almost three years ago, Kelly became a parent and through her own breastfeeding experience became passionate about the subject. She now proudly calls herself a breastfeeding advocate. At the time, the Nevada State Health Division did not have a formal Breastfeeding Program. With help from other colleagues and with the support of our Administrator, the Breastfeeding Program was created. Kelly works with the MCH Program and the WIC Program to improve breastfeeding initiation and duration rates for the entire Nevada population. She coordinates and organizes the Breastfeeding Task Force of Nevada, the Carson City Breastfeeding Coalition, and has started a monthly breastfeeding support group in Carson City.

Andrea Rivers has recently taken over as the Injury Prevention Program Coordinator for the Nevada State Health Division, managing all aspects of this federally funded program. Andrea coordinates the Injury Prevention Task Force which meets quarterly. Andrea currently supervises three people including the new Injury Prevention Biostatistician. Andrea sits on many injury and trauma related committees and advisory groups. Andrea is also responsible for all aspects of the Nevada State Trauma Registry within the Nevada State Health Division. Andrea maintains, performs quality control, assessment and analysis on data from various databases such as mortality, inpatient hospital discharge, trauma and birth. Andrea utilizes appropriate statistical methodologies and software to compile, validate, analyze and disseminate health data for grant applications, statistics requests and statistical and analytical reports.

Michelle Khau is the MCH Biostatistician/SSDI Coordinator for the Office of Health Statistics and Surveillance. The office houses vital records, communicable diseases, hospital discharge, STD, HIV, TB, Birth Defects and Newborn Screening datasets. Michelle maintains, perform quality

control and assessment on and extract data from various databases such as birth, newborn screening and the Birth Defect Registry. Michelle writes syntax to import, clean and manipulate data into proper format for statistical analysis. Michelle maintains the MCH Data Warehouse and Nevada Interactive Health Database System and coordinating the MCH Needs Assessment Project. Michelle collaborates with staff from the Bureau of Child, Family, Community Wellness on projects related to Maternal and Child Health (MCH). Michelle links and matches databases using both exact and probabilistic matching procedures and software. Michelle utilizes appropriate statistical methodologies and software to compile, validate, analyze and disseminate health data for grant applications, statistics requests and statistical and analytical reports. Michelle uses all of these datasets, linkages and collaborations to share the results and advance MCH knowledge towards progression with Nevadans, legislators, media, and other state/federal organizations.

Brad Towle is the MCH and Newborn Screening data person. Mr. Towle received his BS from San Francisco State University, and has two MAs. He has a MA in Biology from San Francisco State University and a MA in Public Administration from the University of Montana. His CV may be found in the attachment to III D.

An attachment is included in this section.

E. State Agency Coordination

As indicated in III.C, the agencies of public health (State Health Division), mental health (Division of Mental Health/Developmental Services), social services/child welfare (Division of Child and Family Services), Medicaid and Nevada Check Up (Division of Health Care Financing and Policy), Aging and TANF and Child Care (Welfare) are located within the Department of Human Resources. The Bureau works closely with all the Divisions of DHR to promote MCH priorities and objectives, described below. (see attached organization chart)

The Bureau works closely with all the Bureaus of the SHD in one manner or another as discussed in III.B and IV.B and IV.C. This includes the Bureaus of Alcohol and Drug Abuse (BADA), Health Planning and Vital Statistics (HP&VS), Health Protection Services (HPS), Community Health (BCH), Licensure and Certification (BLC), and the newest Bureau, the Bureau of Early Intervention Services (BEIS) which joined the SHD in FY04. The main office of BEIS is collocated with the Bureau in Carson City.

The Bureau partners with the Department of Education and with local (county) school districts around the state on many initiatives around child and adolescent health. These include the Youth Risk Behavior Survey (which includes the Safe and Drug Free School Survey), Teen Pregnancy Prevention, and Perinatal Substance Abuse including Fetal Alcohol Syndrome Prevention. It works with the Department of Education on an oral health curriculum for schools. The Bureau also works with Juvenile Probation of the Department of Corrections on teen pregnancy prevention, substance abuse, and injury prevention.

The Bureau is partnering through the MCH Campaign with the Department of Corrections to promote healthy birth outcomes in incarcerated women and good parenting. The Perinatal/Woman's Health Consultant is developing training modules that will be used by Department of Corrections staff, including one on the stages of pregnancy and another on an infant's health. Modules have also been completed on Postpartum issues and Infant Development.

The 2001 Nevada Legislature passed AB513, which appropriated funds for the development of four long-term strategic plans relating to the health care needs of Nevada residents. The project was lead by a Steering Committee to which four Task Forces report, one of which is for Disabilities. The other Task Forces were for Seniors, Rural Health and Rates.

The Disability plan was charged to "ensure the availability and accessibility of a continuum of

services that appropriately meet the basic needs of persons with disabilities in Nevada". Based on this study the 2003 Legislature moved Community Based Services from the Department of Employment, Rehabilitation and Training (DETR) to DHR and also created in DHR a new Office of Disability Services and moved DETR's Traumatic Brain Injury program into it. The Bureau is working very closely with the new Office of Disability Services and Community Based Services. In particular the Office of Disability Services is working closely with the Real Choice Systems Change (RCSC)project discussed in III B.

The RCSC project team has developed an interagency working group to bring all providers of services for the CSHCN population together. This CSHCN Advisory Council's membership includes parents of CSHCN, adolescent CSHCN, advocates, providers, and educators. The Advisory Council serves to guide project activities and to provide a forum for issues of interest to Nevada's CSHCN and their families. The Real Choice program manager acts as a liaison between the Advisory Council and the Children's Disability Subcommittee created as part of the Disability Task Force to assure that project activities are in line with the objectives of Nevada's Strategic Plan for People with Disabilities. While coordination with some agencies is easier than with others, there has been interest in developing a cross-departmental system of care for CSHCN and the RCSC project is working to take advantage of this culture of change.

The Real Choice Project Team has also been attending meetings of and working with the Transition Forum, a subcommittee of the Governor's Council on Rehabilitation and Employment of People With Disabilities. This forum addresses issues inherent to transitioning youth with special health care needs and has formal relationships with DETR and school districts.

The Bureau works closely with the University of Nevada School of Medicine (UNSOM). The Birth Defects Registry initiative currently in process will partner with the UNSOM Department of Pediatrics' Geneticists to provide consultation in its development and implementation. Bureau staff contract with some and otherwise support UNSOM participation in multi-disciplinary clinics for CSHCN that include Genetics, and Cleft/Craniofacial clinics in Reno and Las Vegas. In 2005 the Bureau is working with the geneticist of UNSOM to establish a Fetal Alcohol Syndrome (FAS) multidisciplinary clinic in Las Vegas. Once this clinic is established a plan will be created to have a FAS clinic in the north. The Bureau also works closely with AHEC, whether it is using their expertise to plan and conduct meetings or the partnership with PCDC on rural mental health issues.

The Bureau partners closely with the Clark County Health District (CCHD) and Washoe County District Health Department (WCDHD), which both have MCH programs. A third Health District, Carson City (which is a County), was added late in 2004. There are now three county health departments in Nevada. The remaining 14 counties are served through the SHD. Representatives of the CCHD and WCDHD sit on the Maternal and Child Health Advisory Board and work very closely with the Bureau on MCH issues. /2007/ The CCHD has been renamed to the Southern Nevada Health District (SNHD).//2007//

Through the PCDC the Bureau works very closely with the Great Basin Primary Care Association (GBPCA, the state's PCA) and its members to promote access to primary, dental and mental care for underserved Nevadans. These members include Federally Qualified Health Centers, Tribal Clinics, Rural Health Centers, Nevada Health Centers, etc. The executive director of GBPCA is the current chairman of the Maternal and Child Health Advisory Board. Nevada Health Centers has just become a WIC provider in southern Nevada.

The WIC Program is in the Bureau and partners with many of the other programs in the Bureau such as Oral Health and Women's Health/Perinatal. In the past year WIC has been turning its state-run clinics over to local community-based organizations who are now partners with WIC. It has also gained additional WIC agencies in Clark and Washoe Counties. As this is written there are state-run clinics in just Douglas,Churchill, Humboldt, and Pershing counties; the rest are run by CBOs that include Family Resource Centers, a Head Start, Nevada Health Centers, and a

hospital. A proposal by Pershing County to take over WIC was received in June 2005. /2009/ Agency coordination continues between WIC and MCH staff. Breastfeeding and immunization initiatives are among the two activities under way in 2009. Efforts are beginning to open WIC clinics within Early Intervention Services in the north and south. This effort will increase the coordination among the three agencies and improve our follow up and tracking of children with special health care needs. //2009//

The Teen Pregnancy Prevention initiative works with the various Family Planning organizations in the State, including those services of the Community Health Nurses of BCH and the private organizations in Reno and Las Vegas. In 2004 Nevada was one of several states selected to work together on developing a common Action Plan around Teen Pregnancy, STD, and HIV/AIDS prevention. This initiative is continuing and will continue into FY 06. The Stakeholders Group, as it is called, is now looking at approaching the issues of teen pregnancy, HIV and STD prevention from an adolescent risk reduction perspective. This will be discussed more under National Performance Measure 08.

The Oral Health initiative also has many partnerships. The State Dental Health Consultant (to the CDC grant) is from the University of Nevada Dental School. The initiative has both a state advisory committee and local coalitions in Reno, Washoe, and Lyon counties, with more in process. Members of the various coalitions and the state advisory committee include representatives of the State Dental Association, State Dental Hygienists Association, the State Board of Dental Examiners, UNSOM, the Dental School, consumers, the GBPCA, Washoe County District Health Department, Clark County Health District, Tribal Health, local Churches, a hospital and the State Aging Division. Meetings are usually attended by representatives of other public agencies that include Medicaid and the Nevada Public Health Foundation. /2009/ The Oral Health Program non longer contracts for the services of a State Dental Health Consultant.

Through the partnership the Bureau has with Medicaid and Nevada Check Up, Bureau programs are referral sources for both programs. Bureau staff are able to access the Medicaid data system to confirm Medicaid eligibility or ineligibility when considering eligibility for the CSHCN Program. The Bureau has a contract with Nevada's Division of Health Care Financing and Policy (Medicaid) to provide public education through the Maternal and Child Health Campaign about the importance of early and continuous prenatal care, other pregnancy related issues and infant care. Pregnant women and infants and children are also informed about the Medicaid (including EPSDT) and Nevada Check Up programs and referred to the programs if indicated. In addition, the Real Choice Systems Change project has worked with Medicaid and Nevada Check up staff on an outreach campaign to sign children up for Medicaid and Nevada Check Up, and perform outreach for CSHCN services at the same time. The Bureau's pilot projects for RCSC will work with DHCFP to increase EPSDT usage by Medicaid children, a goal of the grant.

The CSHCN program also uses SSI for a referral. Program regulations require a denial from Medicaid, SSI, and Nevada Check Up for those children whose family income and for SSI the child's condition appear to meet those eligibility criteria.

Through the various programs in the Bureau the Bureau has contact with all the birthing facilities in the State. It works with them on issues such as newborn screening, newborn hearing screening, the Birth Defects Registry, and the MCH Campaign. In 2004 it worked with representatives of all the NICUs in the state to revise the NICU regulations that are in NAC.

Along with moving all Early Intervention Services to the SHD, the Director also moved the Head Start State Collaboration to the Welfare Division with the Child Care Unit. The 2005 session is now moving it to the DHR Director's office. The Bureau has representation on both the Head Start State Collaboration (the Bureau Chief and Oral Health) and the DHR Child Care Advisory Committee (the Bureau Chief) and ensures that health needs including those of CSHCN are part of every discussion of services. Both the Head Start State Collaboration and DHR Child Care Advisory Committee have similar memberships and frequently have similar agendas items. In

June of 2005 it became clear that the Head Start mandate to a strategic plan and the Early Childhood Comprehensive Systems (ECCS) strategic plan are addressing the same populations. The two initiatives are being combined to produce one plan for ECCS that includes Head Start.

As noted in III.B, the Child Care Health Consultant (CCHC) program is in transition due to lack of funding and loss of their lead Child Care Health Consultant trainer. The MCH funded member continues to be available to child care providers for consultation and to train staff in the prevention of illnesses within a child care setting. The Bureau's Early Childhood Comprehensive Systems program is working to continue this program. The CCHC leadership is being transferred from the University of Nevada, Reno, to the Bureau where it is being integrated into the ECCS program. The Bureau is awaiting word on where the training for CCHC trainers (train the trainers) will be in the future. Plans are to send two or three community health nurses from BCH for training as trainers. They will then train all the CHCs as CCHC. This will take care of rural communities. The Welfare Division, Child Care Unit, has agreed to cover the salaries of two nurses who are already trained in Washoe County. This will leave Clark County with a need for CCHC trainers, which will not be addressed until next year.

As previously noted DHR is became the Department of Health and Human Services (DHHS) in 2007.

A Fetal Alcohol Syndrome multidisciplinary clinic has been established in Las Vegas. Plans continue to develop one in the north.

Pershing County is no longer a state run WIC clinic, leaving just Douglas, Churchill and Humboldt counties for the state.

/2010/ The Maternal and Child Health Advisory Board has a new chair, Beverley Neyland, MD, AAP President. The board held a MCH meet & Greet with legislators on March 12, 2009 during session. Their priorities and mission are posted on the Health Division website http://www.health.nv.gov/MCH.htm //2010///2011/The new chair for the MCHAB is Candy Hunter, MEd. Candy is currently the Clinical Supervisor for the Washoe County Health District. Candy attended the 2010 AMCHP conference and met with state and national legislators carrying the message of MCH. //2011//

The Oral Health Program convened a one-day coalition building workshop for members of Nevada's oral health coalitions in Las Vegas on June 5, 2006. There are now 6 oral health coalitions in the state, one in Reno, one in Las Vegas, one for rural Carson City and Douglas Counties, a northeast coalition, a central Nevada coalition, and a newly forming one in Churchill, Lyon, Pershing and Storey Counties. Other activities continue as listed.

Unfortunately the plan to address the Child Care Consultants has had to be put on hold due to staff changes.

Collaborations and Coordinations for the Teen Pregnancy Prevention initiative are discussed in the Annual Plan for NPM 8 and SPM 4.

As noted in III D there are no longer state run WIC clinics.

/2010/ The ECCS State Plan is in the process of being completed and will be finished by the end of July 2006. The ECCS Plan was completed and is in the implementation stage. The ECCS program has merged with the statewide Head Start office. The current grant is fully implemented and the new partnership was successful in being awarded a new ECCS grant. A thriving early childhood group is active and prepared a LAUNCH proposal to further support the early childhood activity. //2010//

Funding for additional FAS Clinics was requested during the 2007 Legislative session and was approved. as noted in III B Agency Capacity. This initiative is a partnership between the Bureau, UNSOM, private providers and BEIS.

The Child Care Health Consultant initiative is being revitalized. The Medical Consultant, the ECCS Coordinator and other agency staff went to training in North Carolina in June 2007. They came home with a train the trainer model which they hope to take around the state.

As previously noted the RCSC project ended and segued into MCH supported CSHCN Systems Development. A primary focus now is promoting the use of Medicaid's Early Periodic Screening, Detection and Treatment (EPSDT) for children so that all Medicaid eligible children receive the services they need according to the established periodicity schedule. Due to the tightness of the budget there will be only one pilot project operational in the coming year, the one in Elko. //2008//

/2009/ As with last year there is not much change. As previously noted FASD Clinics will be expanded when the identified funding is finally in hand.

The Child Care Health Consultant continues with new help from the Southern Nevada Health District (Clark County). They will be having community health nurses trained to work in that county.

The Chairman of the MCHAB is now a pediatrician who is with the University of Nevada School of Medicine. She has been the Chapter President for the state AAP.

The MCH Manager is a member of the Lead Team for the Head Start Partnership. As such she represents health, which is a priority for Head Start. The Head Start Partnership meets regularly to discuss how to address the priorities of the program; the lead team meets in the interim to provide guidance to the office. Both the MCH Manager and the Early Childhood Wellness supervisor are Partnership members.

The Bureau Chief continues on the Child Death Administrative Review team; the Medical Consultant continues on the Child Death Executive Committee team.
//2009//
//2011//

F. Health Systems Capacity Indicators

Introduction

The Center for Health Data and Research (CHDR) is the major provider of data for the MCH Block Grant application. The CHDR systems centralize data from their original sources, clean and standardize the data, and perform linkages to produce the data required for the construction of the different sets of indicators, such as NPMs, SPMs, OMs, SCHIs and HSIMs, required by the application.

There are 30 databases in MCH Data Warehouse which include:
a. Birth data
b. Death data
c. Hospital discharge data
d. WIC
e. Medicaid claims data
f. Census and Demographic data
g. Trauma Registry data
h. Injury data

The CHDR is completing the implementation of the Electronic Death Registry System. The data are still undergoing quality assurance processes, but CHDR is able to produce some preliminary

figures for 2007.

During the last year the CHDR has improved its capability to process more and better public health data. The Death Registry is now electronically managed. The improved quality of the data will increase the reliability and the capability for linkages, thus improve the availability of data.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	46.4	34.6	34.3	42.2	42.2
Numerator	833	648	667	826	826
Denominator	179563	187271	194467	195925	195925
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data entered is from 2008. Data will be available in December 2010.

Notes - 2008
ICD-9 codes 493-493.9 listed in any of the diagnosis fields were used to compile the hospital discharge data. Age 0-4.

Notes - 2007
ICD-9 codes 493-493.9 listed in any of the diagnosis fields were used to compile the hospital discharge data. Age 0-4.

Narrative:
/2010/ CSHCN staff are in partnership with the Managed Care Organization and Amerigroup to raise awareness about the Asthma-Obesity Link for youth. //2010//This collaborative brings together Anthem's Obesity Task Force, the Nevada State Health Division, the American Lung Association, and the University of Nevada, Reno. This collaborative is driven by the WellPoint Asthma Initiative and the National Health Promotion Asthma Initiative.
From 2005 to 2006 children less than 5 years of age who were hospitalized for asthma dropped 25%.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	73.9	97.8	93	93.0	94.6
Numerator	10917	15765		15852	16412
Denominator	14775	16125		17045	17346

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data is for federal fiscal year 2009.

To avoid additional duplications between HMOs, Anthem's information was not included in this report as all members were moved to another HMO.

*416 Caveat: Please note the number of screenings given to newborns on Line 11 exceeds the number of eligibles entered on Line 1. There are several factors contributing to this anomaly, the most significant being the number of newborns enrolled in both of Fee For Service population and one (or more) HMOs during the same fiscal year. In fact, we found that 40% of our newborns met this condition.

Notes - 2008
See the note for 2007. The systems change is not yet in place. This is an estimate based on last years's actuals. The total number of children under one is 17045.

Notes - 2007
The data is from Medicaid. The numerator is higher than the denominator because Medicaid has to combine four different data sources to get "patient level" data (Health Plan of Nevada, Anthem ,Nevada Care, and FFS). There are duplicates between the data sources since Medicaid does not require lock-in enrollment period. (i.e. members can bounce between HMOs and FFS from month to month).
Medicaid has no way yet of tracking the duplicates.

The denominator is an unduplicated count directly from Medicaid payment system.

Because percentage is over 100, system does not allow us to input the data so the true counts are listed below:

%= 108.3%
numerator: 17,813
denominator: 16,451

It is the expectation to get a unduplicated number by fall 2008. DHCFP is currently involved in an initiative to import encounter records data from their HMO participants into their claims payment and data warehousing systems. The project is scheduled for completition by fall 2008.

Narrative:
The NV Medicaid RACC Unit, provides the data to build this indicator. The numerator is extracted from claims payment databases, that currently does not have the ability to resolve overlaps (duplicated records) and the denominator is extracted from elegibility databases which are unduplicated figures. Thus, the indicator for 2007 is showing a ratio bigger than 1. The Division of Health Care Financing and Policy (DHCFP) is currently involved in an initiative to import encounter records data from their HMOs participants into their claims payment and data warehousing systems. The improvement will allow the system to solve the inconsistancy produced by the overlaps. This project is scheduled for completition by Fall 2008. /2010/ 2008 data is also incomplete as the Managed Care Organizations have changed vendors again.

//2010//

HCSM # 2 continues to see an increase. Medicaid managed care continued to have two providers each in northern and southern Nevada. A new HMO contract was negotiated bringing on Anthem Blue Cross to Health Plan of Nevada, which are the two Medicaid (and Nevada Check Up) HMOs in the state. /2010/ A new contract with Amerigroup was effective February 2009. //2010//The MCH Campaign's Information and Referral Line (IRL) continues to refer called to providers who will accept Medicaid. The MCH Campaign is a partnership between SHD and Medicaid. Medicaid reported this data.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	91.7	39.5	65.9	82.4	82.4
Numerator	881	456	1271	319	319
Denominator	961	1153	1930	387	387
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data is for federal fiscal year 2009.

To avoid additional duplications between HMOs, Anthem's information was not included in this report as all members were moved to another HMO.

416 Caveat: Please note the number of screenings given to newborns on Line 11 exceeds the number of eligibles entered on Line 1. There are several factors contributing to this anomaly, the most significant being the number of newborns enrolled in both of Fee For Service population and one (or more) HMOs during the same fiscal year. In fact, we found that 40% of our newborns met this condition.

Notes - 2008
Entered federal fiscal year 2009 data.

CMS 416 for SCHIP data will be available this fall.

Notes - 2007
This data came from Nevada Check Up

Narrative:
The data required to build this indicator is provided by the NV Medicaid RACC Unit. The DHCFP is undergoing a process of data warehousing and other improvements to increase their data quality and availability.

HCSI # 3 has seen a decrease. This data is from Nevada Check Up. The rates can also be linked

to managed care as children in both Reno and Clark County have to belong to the Medicaid managed care agencies in those communities. The Nevada State Legislature has continued to approve increased state funding to match the SCHIP dollars.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	69.1	68.6	67.1	67.8	67.8
Numerator	25667	27343	27550	26207	26207
Denominator	37133	39876	41041	38642	38642
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data entered is from 2008.

Due to the data being half electronic and half hard copy, and a change in birth certificate, the syntax had to be recoded to recheck Kotelchuck Index. The data may be available in December of 2010.

Notes - 2008
Data is preliminary, will be available in December 2010.

Narrative:
This specific indicator is obtained from the breakdown by age , from record originated within the Inpatient Hospital Discarge, ICD9 codes 493.0-493.9. The statistics shows a consistent improvement in the indicator.

/2010/ CSHCN staff are in partnership with the Managed Care Organization and Amerigroup to raise awareness about the Asthma-Obesity Link for youth. //2010//This collaborative brings together Anthem's Obesity Task Force, the Nevada State Health Division, the American Lung Association, and the University of Nevada, Reno. This collaborative is driven by the WellPoint Asthma Initiative and the National Health Promotion Asthma Initiative.
From 2005 to 2006 children less than 5 years of age who were hospitalized for asthma dropped 25%.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	30.8	78.4	38.4	36.6	97.6

Numerator	43250	151261	59161	59747	167240
Denominator	140403	193011	154025	163407	171267
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The data is for federal fiscal year 2009.

Numerator was obtained by combining HMO & FSS totals, duplicate may exist. The denominator was obtained through DSS and has no duplicates. Medicaid does not track potential eligibility, only eligibles. Data from the HMOs did not include Anthem's totals from the first quarter of the fiscal year.

Notes - 2008
HEALTH SYSTEMS CAPACITY INDICATOR #7A
This refers to question 10 on the MCH Report is answered by dividing CMS 416 question 4 by question 3.

Notes - 2007
HEALTH SYSTEMS CAPACITY INDICATOR #7A
This refers to question 10 on the MCH Report is answered by dividing CMS 416 question 4 by question 3.

Narrative:
HSCI 7a no changes in year 2010.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.3	29.7	35.2	41.8	54.5
Numerator	7569	8638	10078	12755	20006
Denominator	28746	29040	28670	30527	36700
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
The data is for federal fiscal year 2009.

Data is from the CMS 416.

Notes - 2008
This data came from question #1 on the CMS 416 report.

Notes - 2007
data provided by Medicaid

Narrative:
The health status indicators are addressed in new state perforamcnce measure.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	20.8	19.0	0.4	0.4	0.3
Numerator	1054	1044	22	22	19
Denominator	5077	5486	5674	5674	5901
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
PLEASE REVISE with a note explaining these numbers, as these NUMBERS DON'T LOOK RIGHT!!!

Notes - 2007
The number served is from the Bureau of Early Intervention Services, which is where the CSHCN program serves those on SSI (0-3 yrs old), through early intervention and the multidisciplinary clinics. The denominator is from the U.S. Social Security Administration Office of Policy, SSI Recipients by State and County 2007 for children.

Narrative:
This service is provided through our SCHIP program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2008	other	8	8	16

Notes - 2011

Medicaid data is for FFY 09 & Non-Medicaid data is CY 08.

Used counts from Medicaid and non-medicaid. We did not match data files and payment sources is not on birth certificate.

Narrative:
The CHDR provides data on the statewide figures. The data is extracted from the Birth Registry System. The NV Medicaid RACC Unit is reporting the data specifically for Medicaid figures. The indicator is built from both sources of data.

HSCI # 5A. The Bureau partners with Medicaid and Nevada Check Up to get underserved women into prenatal care either in to prenatal care through the MCH Campaign or enrolled in Medicaid or Nevada Check Up. Once again low birthweight shows little variation between the two populations. This data comes from the CHDR data warehouse and Medicaid.

Early and continuous prenatal care can reduce poor birth weight infants. The Bureau continues to work with Medicaid and Nevada Check Up to promote access to prenatal care to underserved women. The MCHAB prenatal subcommittee will focus its priority area on access to prenatal care and coverage for eligible pregnant women through initiatives and policy as possible in FY 09 and FY 10.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	other	6	5.3	11.3

Notes - 2011
Medicaid data is for FFY 09 & Non-Medicaid data is CY 08.

Used counts from Medicaid and non-medicaid. We did not match data files and payment sources is not on birth certificate.

Narrative:
The CHDR is completing the implementation of the EDRS and, as expected, the databases are undergoing quality assurance and control to assure the system's reliability. CHDR is providing final dat for 2005 and preliminary data for 2006, 2007 is an Estimated based in the 2003-06 data.

HSCI # 5B. This data is provisional. The CHDR does not have 2006 data yet and this is an estimate. Medicaid data came from Medicaid.
The Bureau is working to promote early and continuous prenatal care that can reduce infant deaths. Screening of pregnant women for complications can reduce poor birth outcomes and reduce infant deaths. MCH program works in collaboration with CDR committees, injury programs, and other childhood/infant health education programs throughout the state in FY 09 and FY 10.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	other	10.2	69.4	79.6

Notes - 2011
Medicaid data is for FFY 09 & Non-Medicaid data is CY 08.

Used counts from Medicaid and non-medicaid. We did not match data files and payment sources is not on birth certificate.

Narrative:
Medicaid 2007 numbers were obtained from HEDIS and provided by the NV Medicaid RACC Unit. They contain data from both HMOs serving Medicaid. Non-Medicaid numbers were provided by CHDR fron the Birth Registry System.

HSCI # 5C. See the note for 5A. In addition Nevada Check Up received a HIFA waiver and raised the income guidelines for coverage of prenatal care for all women to 185% FPL effective December 2006. This will give more women coverage for prenatal care when fully implemented.

The Bureau continues to promote early prenatal access for underserved pregnant women through our MCH information and referral line, direct services, and outreach and education in FY 09 and FY 10.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	other	10	67.8	77.8

Notes - 2011

Medicaid data is for FFY 09 & Non-Medicaid data is CY 08.

Used counts from Medicaid and non-medicaid. We did not match data files and payment sources is not on birth certificate.

Narrative:
As reflected in the 5A to 5C, Medicaid 2007 numbers were obtained from HEDIS and provided by the NV Medicaid RACC Unit. They contain data from HMOs serving Medicaid. Non-Medicaid numbers were provided by CHDR from the Birth Registry System.

HSCI # 5D. See the notes for 5A and 5 C. Efforts to get more women coverage for prenatal care should lead to more women having an adequate number of prenatal visits. This data is from Medicaid and the CHDR.

For 2008 see notes for 5A -5C. Efforts continue to provide access and information/education on the importance of early and continuous prenatal care. Although for 2008 our percent of 68% was lower than expected, efforts continue to promote prenatal care and new initiatives are in place to improve for 2009 and 2010.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
There are no changes from 2006 in the poverty levels for eligibility for 2007. No changes in 2008. The data was obtained from the last update of the Medicaid and SCHIP Elegibility and Payment Manual, available on the Division of Welfare and Supportive Services' Website.

HSCI # 6. The information is contained in Medicaid and Nevada Check Up manuals and on their websites. As previously noted, Nevada Check Up raised eligibility for pregnant women over age 18 to 185% FPL. This waiver was implemented December 2006. WIC agencies have been advised of the change and are a referral source for pregnant women who come into the WIC clinics with no source for prenatal care.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 6)	2009	133

(Age range 7 to 18) (Age range to)		100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2009	200

Narrative:
There are no changes from 2006 in the poverty levels for eligibility for 2007. 2008 remains the same. The data was obtained from the last update of the Medicaid and SCHIP Elegibility and Payment Manual, available on the Division of Welfare and Supportive Services' Website.

HSCI # 6B. This data has not changed with the exception of the Nevada Check Up coverage of pregnant women.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Narrative:
Notes - 2010
To age 18 pregnant women can get on Medicaid. There is a waiver for women to 185% of poverty for up to 100 women.

Notes - 2010
Pregnant women for SCHIP are eligible only to age 18.

Narrative:
There are no changes from 2006 in the poverty levels for eligibility for 2007. 200 remains the same. The data was obtained from the last update of the Medicaid and SCHIP Elegibility and Payment Manual, available on the Division of Welfare and Supportive Services' Website.

HSCI # 6C. This data has not changed with the exception of the Nevada Check Up coverage of pregnant women.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2011

Narrative:
MCH staff has data partnerships with Medicaid data staff and data staff in vital statistics.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
MCH partners screen women of child bearing age for tobacco use, we also use data from YRBS for interventions.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Nevada's priorities and initiatives are based on the MCH/CSHCN Five-Year Needs Assessments completed in January and May 2005. "Focus groups" were established to publicly discuss the inadequacies and inequalities among the 3 MCH populations in Nevada (pregnant women and infants, children and adolescents, and CSHCN). The focus groups were a tool to build bridges among traditional and non-traditional partners in the community; they were a primary source of information that helped shape the foundation of the Year 2000 Needs Assessment. In an improvement over the 2000 Needs Assessment, the Bureau was able to utilize the data warehouse in the CHDR for Primary and Secondary data sources. No additional surveys needed to be done. Presentations were also made to the Maternal and Child Health Advisory Board and the Governor's Youth Advisory Council, and a statewide video-conferenced public hearing was held to discuss preliminary findings and shape the final outcomes of the Needs Assessment. The persons involved in the Year 2005 Needs Assessment were very vocal, creative, and mindful of the populations they serve. /2009/ /2009/ Through the Bureau's activities and coalitions related to MCH issues we have heard to ongoing needs of our communities and have had the opportunity to adjust our programs and activities to reflect the changing needs of our state. //2009//

/2010/ In response to the bureau's strategic planning, reorganization, and this year's MCH Advisory Board's priorities the Nevada MCH priorities are updated as follows:

The Nevada Maternal and Child Health Advisory board determines the four priority areas to address in
2009 are: a) Prenatal Access, b) Immunization Rates, c) Dental Sealants, and d) Access to Mental Health
Services
• Activities to address the above will range from policy changes for eligibility; rates changes to maintain an
adequate provider network; implementation of best practices; education and awareness campaigns; and
increased availability of data specific to these priority areas.
• Increase access to primary care services, oral health services, and mental health services, with an emphasis
on medical home concepts, online applications, and electronic medical records when possible.
• Create a linked online data collection, surveillance, and reporting system related to services delivered to
the MCH populations.
• Decrease the incidence of domestic violence among women of childbearing age.
• Increase breastfeeding
• Maintain smoke free environments in public places; establish healthy homes initiatives //2010//

The priorities identified by the Year 2005 MCH Needs Assessment include:

An overarching approach to Nevada's priority needs identified below, continues to be to identify ethnic, gender and age demographics of targeted populations, and use culturally appropriate assumptions and strategies to design and implement initiatives.

1. Increase access to primary care services, providers, facilities, resources, and payor sources among the MCH populations.
2. Increase access to oral health services, providers, facilities, resources, and payor sources among the MCH populations.

3. Increase access to mental health services, providers, facilities, resources, and payor sources among the MCH populations.
4. Create a unified data system and surveillance system to monitor services delivered to the MCH populations.
5. Create "braided" services for CSHCN resources in Nevada including "one-stop-shopping" and "no-wrong-door" models of service delivery.
6. Increase financial coverage and decrease financial gaps for health services among the MCH populations
7. Decrease the incidence of domestic violence among women of child-bearing age
8. Decrease the risk factors associated with obesity for children and women
9. Decrease unintentional injuries among the MCH populations

/2010/ The State Performance Measures have also been updated to:

Increase the percent of women of child-bearing age who receive screening and assistance for domestic violence.
Increase the rate of significant Medicaid dental providers to the Medicaid population of children, youth and pregnant women.
Decrease the percent of women, ages 18 to 44, who are obese.
Decrease the percent of children and youth ages birth through 18 who die from unintentional injuries.
The percent of women (18-44) who feel down or depressed should be decreased.
Increase the number of schools (grades kindergarten to high school) that have access to a school based health center.
Reduce the prevalence of Fetal Alcohol Spectrum Disorders (FASD).
Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age.
Increase the percentage of children screened for age-appropriate developmental skills and behavioral health levels.
Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools. //2010//

Outcome Measures (OM)1 through 5 lead to the issue of achieving a healthy pregnancy and birth outcome. For FY08, the primary efforts of the MCH Program on achieving healthy birth outcomes will be achieved through the Bureau's MCH Campaign and Child and Adolescent Health Programs discussed in III B. The Teen Pregnancy Prevention campaign will continue to work to prevent teen pregnancies, which can lead to low birthweight babies.

The 2003 Legislative session established a Child Death Review process that involves 2 teams, staffed by DCFS. One team is Executive, on which the Bureau's Women's Health Coordinator sits representing Public Health. It is charged with reviewing child death reports from local teams and making recommendations for state policy changes and outreach campaigns to change behavior. It is comprised of representatives of child death review teams from around the state, public health, vital records, medical personnel, law enforcement, the office of the Attorney General, and a coroner.
/2011/Performance, priorities and activities are noted throughout this document. OUr 2010 needs assessment's initial steps are complete and with interpretation of the data collected priorities and the capacity for addressign and deciding priorities will be the next steps along with evaluation.

B. State Priorities

Driven by the recent reorganization, integrated programming, and staff training/capacity building to use performance measures in their daily tasks, our state performance measures have been updated to the following:

Increase the percent of women of child-bearing age who receive screening and assistance for domestic violence.
Increase the rate of significant Medicaid dental providers to the Medicaid population of children, youth and pregnant women.
Decrease the percent of women, ages 18 to 44, who are obese.
Decrease the percent of children and youth ages birth through 18 who die from unintentional injuries.
Decrease the percent of women (18-44) who feel down or depressed.
Increase the number of schools (grades kindergarten to high school) that have access to a school based health center.
Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age.
Increase the percentage of children screened for age-appropriate developmental skills and behavioral health levels.
Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools.

These state performance measures were updated to support community interest for addressing current conditions, and reflect the changed priorities. In the past, state performance measures were limited to those for which there was data. Now staff are approaching the choices from which areas need to be addressed. We still lack adequate data, but feel the focus and attention will move us toward monitoring capacity. In some cases, we recognize steps required for data collection will be the primary strategies initiated. Progress will be marked by the development of data resources. For other measures, more sophisticated activities are proposed such as translating existing data into useful forms for our coalitions, policy development, and advocacy in preparation for the 2011 legislative session. (see attached briefs from the MCH Advisory Board) In the 2009 legislative session, the MCH Advisory Board presented a priority packet for each of these areas: Access to Prenatal Care, Immunization Rates, Behavioral Health Assessments/Mental Health, and Dental Sealants. THese are more refined list of state priorities (supported by the national performance measures). The Advisory Board will create their short list of priorities they focus on to develop into community messages and create advocacy movements around their topics.

Data continues to be a challenge, however, the Nevada Interactive Health Databases, http://www.health.nv.gov/NIHDS.htm, and the HRSA Data Resource Center are essential tools. MCH Staff are planning to add to their available data with a potential PRAMS pilot and exploring a data system or surveillance for FASD. In 2011 prioriteis have not changed for our MCH partners and MCH Advisory Board, our partners are currently awaiting initial results from the needs assessment. Our PRAMS pilot and other surveillance systems will provide valuable data for setting priorities. Assessing needs with qualitative and quantitiative data sources along with assessing our capacity to address these needs will lend itself to our priorities in coming years

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99	99	99	100	100
Annual Indicator	98.4	100.0	100.0	100.0	100.0
Numerator	35794	49	51	44	43
Denominator	36377	49	51	44	43
Data Source				Oregon Public	Oregon Public

				Health Lab	Health Lab
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

The Nevada NBS Program continues to screen children in Nevada for 34 disorders and ensure positive cases receive necessary services within the state. Positive metabolic cases are referred to the metabolic clinics offered through the states' contract with Dr. Nicolo Longo. The Program also continues to work closely with hospitals and healthcare providers to educate the heath care community about the program, and provide education when necessary. This currently includes redesigning the feedback process to hospitals. The program is working with the Nevada Hospital Association to display hospital statistics on the state website. The intent is to make hospital statistics available to the public to ensure accountability and provide citizens of the state more knowledge of hospital activities around the Newborn Screening Program.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Nevada NBS program screened 98.7% of infants born in the State and 86.4% of these infants received a second screening.			X	
2. The Nevada NBS program supports specialty metabolic clinics for children determined to have a metabolic disorder.		X		X
3. The Nevada NBS and CSHCN programs provide coverage for the diagnosis and treatment of metabolic, endocrine and hemoglobin disorders.	X	X		
4. The Nevada NBS and CSHCN programs work with Early Intervention services to provide specialty nutrition services to families of children born with metabolic and other developmental disorders.	X	X		
5. The Nevada NBS program and CSHCN programs maintain a "registry" of NBS cases.				X
6. All infants detected with an inborn error of metabolism, endocrine, or Hemoglobin disorder are autuomatically referred to the CSHCN program for coverage of physician, laboratory, and nutrition services.	X	X		
7. Cystic fibrosis was added to Nevada's newborn screening panel on May 1, 2008.				
8. Funding has been procured to add six new hemoglobin clinics and six new endocrine clinics.	X	X		
9. Through training by the program's nurse consultant, newborn screening sample error rate was reduced from 40% to less than 10%.				
10. The contract with Dr. Nicola Longo from the Univeristy of Utah School of Medicine to conduct Nevada's metabolic clinics is in effect.		X		

b. Current Activities
In the coming year the Nevada Newborn Screening Program plans to expand program activities. These activities include integrating the Newborn Screening Program with the EHDI Program to leverage resources, streamline activities, and increase the efficiency of both programs. The Program will work to expand staff positions to provide a more active role in short-term follow-up and expand the program to provide long-term tracking and follow-up activities. This will include assisting families in the ongoing management of disorders. The program plans to expand education activities around laboratory specimens, program activities, and the purpose of the newborn screening program to healthcare providers around the state. The program also plans to focus efforts on the education of parents planning to have children, and those with a child identified with a disorder. In addition, the program plans to work with parents in Nevada to begin development of family-to-family support services for parents of children identified with a newborn screening related disorder. The NBS Program also plans to focus efforts on the development of the Newborn Screening Advisory Council as a method to provide expert guidance for the program within Nevada. See attached business plan for future Newborn Screening redesign.

c. Plan for the Coming Year
The plan for the coming year include further development of the Newborn Screening Advisory Council. Issues addressed include a parent support group for Hemoglobinopathies with an education component, addressing the addition of metabolic disorders as recommended, building partnerships, and reducing loss to follow up.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**37226**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	36945	99.2	9	1	1	100.0
Congenital Hypothyroidism (Classical)	36945	99.2	489	16	16	100.0
Galactosemia (Classical)	36945	99.2	14	0	0	
Sickle Cell Disease	36945	99.2	9	9	9	100.0
Biotinidase Deficiency	36945	99.2	5	2	2	100.0
Cystic Fibrosis	36945	99.2	264	6	6	100.0
Maple Syrup	36945	99.2	1	1	1	100.0

Urine Disease						
Other	36945	99.2	3	3	3	100.0
Methylmalonic acidemia (Cbl A,B)	36945	99.2	1	1	1	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	36945	99.2	77	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	36945	99.2	2	2	2	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	65	60	50	50
Annual Indicator	54.6	54.6	47.5	47.5	47.5
Numerator					
Denominator					
Data Source				2006 Natl Study	2006 Natl Study
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	60	65	70	70

Notes - 2009
2006 National Study Data repeated.
Increased outcome objectives to be more inline with the national averages of 57.4% (2006)

Notes - 2008
2006 National Study Data repeated.
Increased outcome objectives to be more inline with the national averages of 57.4% (2006)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

MCH staff responded to parents' desire for more information on newborn screening disorders. The Nevada website has links to the Oregon Public Health Laboratory "fact sheets" on newborn screening disorders. These fact sheets provide up-to-date information on the 32 disorders on Nevada's newborn screening panel and include information on cause, symptoms, treatment, and outcomes without treatment. An active parent on the Nevada Advisory Council for CYSHCN is leading action to enact a NBS parent run organization focused on newborn screening issues. The Nevada Birth Outcomes Monitoring system (formerly the Birth Defect Registry) program manager will continue to gather and input case data more frequently so parents can be informed of available assistance and support programs in a more timely manner. To increase cultural competency, the state run CYSHCN helpline will be contracted to the state's Family-to-family Health Information Center (Family Voices). This will increase the hours the phone is offered, provide direct linkage to parent support. In addition, the MCH staff are reviewing ways to meaningfully involve Family TIES and Nevada PEP in the Needs Assessment process for 2010. The parent led Interagency Coordination Council (0-3 years) and other parent groups are providing input for the redesign of how Early Intervention Services cross-refers and coordinates services among Newborn Screening, the CYSHCN program, and other needed services for children with developmental delays.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Per the national CSHCN survey, 54.6% of Nevada families partner in decision making at all levels and are satisfied with the services they receive. The Nevada Advisory Council for CYSHCN meetings are covering topics of concern by parents.		X		
2. Staff will continue to strengthen existing relationships with Family TIES and Early Intervention Services and continues to collaborate with the new partners in the office of Disability Services, Mental Health, Special Education and the County Schools				X
3. Family TIES, Nevada PEP and CYSHCN staff continue to provide cross referral for services.		X		X
4. The Nevada Children with Special Health Care Needs Assessment identified the prevailing needs as improvements in the financial application process and the lack of all provider types.		X		X
5. The Bureau has continued the outreach activities in the rural areas.		X		X
6. Parent direction from the Nevada Advisory Council for CSHCN resulted in a Respite voucher subgrant for rural families. The voucher could be used for relatives or friends so it addressed the disparity/lack of respite services in rural areas.		X		X
7. Parents were active in the Healthy Kids- EPSDT and designed a family-friendly brochure in English and Spanish. It is distributed by welfare (eligibility), Head Start, Family Resource Centers, Family TIES, and Nevada PEP.				
8.				
9.				
10.				

b. Current Activities

To increase cultural competency, a contract to deliver the state's CYSHCN helpline by the Family-to-Family Information Center started after the new State Fiscal Year (July 1, 2009). This enhanced the parent-parent support for the helpline and increase the range of times the help is available. The Nevada Advisory Council for CYSHCN, Hands & Voices, Family TIES, and Nevada PEP will be actively engaged in the upcoming needs assessment process.

2a. Increase family knowledge of supports/resources and family-centered care (based on CYSHCN Needs Assessment) contract with Family-to-family Health Information Center
2b. Redesign of the CYSHCN program; community based contract
2c. Coordinate with EIS for improved transitioning into school system (3-5 years) and early identification of conditions/service enrollment

2d. Coordinate with DETR and InterAgency Transition Board for Youth Health Transitioning work

2e. Increase technical assistance to involve parent lead groups in Needs Assessment process for 2010

2f. (1k.) Coordinate all age appropriate screening under umbrella approaches such as medical home, well child/EPSDT and educate families to seek comprehensive preventive exams and how to pay for services.

c. Plan for the Coming Year
Care coordination through Family Resource Centers will assist children with special health care needs and their families with services and referrals as needed. This parent assistance and involvement will provide support services in the communities where the children live.
Our needs assessment will include feedback from our families with children with special health care needs in order to better address the issues.
Implementation of our cultural competency training to staff will provide the needed understanding of issues to address any health disparities.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55	55	42	47
Annual Indicator	49.1	49.1	41.2	41.2	41.2
Numerator					
Denominator					
Data Source				2006 Natl Study	2006 Natl Study
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	51	55	60	65	65

Notes - 2009
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)
Increased the target objectives to be inline with National averages of 47.1% (2006)

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)
Increased the target objectives to be inline with National averages of 47.1% (2006)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
The Bureau would like to expand collaborations to continue the development of the electronic birth registry to enhance tracking on CSHCN. In addition, program staff will increase collaborations with Early Intervention Services and the Bureau of Community Health, Chronic Disease, to improve tracking and follow-up of CHSCN. Staff would also like to explore the possibility of working with Nevada Blind Children's Foundation and Lyons Club to implement Babies Count (vision registry) and develop newborn vision screening. It would also be beneficial this coming year to receive MCH technical assistance to critically evaluate the existing Newborn Screening program and follow-up. Funding was received by community partners to implement three pilot projects (Reno, Las Vegas, rural counties) to do Informing and Care Coordination based on the Iowa delivery system. Implementation will begin July 1, 2008. Additional funding is available to do health provider training using the Georgetown Bright Futures "Well-Child Curriculum," which includes developmental and behavioral health screening. Another small project provides medical tablets for the rural health nurses who conduct EPSDT exams to enter their chart data and be digitally delivered to the home office. Also, the information can be sent directly to the multi-disciplinary team who does the diagnosis for autism and other developmental delays.

View Attachment

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN and System Change staff continue to work with Medicaid and Nevada Check Up to develop ways of increasing the number of children eligible for and receiving EPSDT preventive examinations.		X		X
2. Staff are reviewing changes to the CSHCN program, which would allow coverage of primary care for the children/youth who are on the program. X X	X	X		
3. The CSHCN and System Change team continue to support the Family TIES proposal for medical home technical assistance.				X
4. . The Healthy Kids-EPSDT workgroups continue to work with state agencies, and medical providers to ensure services are family-centered and delivered in a culturally sensitive approach.		X	X	
5. The new Indian Health Board has recruited new participation to the Healthy Kids-EPSDT workgroups. Their participation raises health disparity issues regarding policy changes needed for same day multiple-encounters, transportation issues, and				X

referral				
6. Case data has been entered into the Nevada Birth Outcomes Monitoring System more frequently so parents are contacted and provided with progam information in a more timely manner.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Physician training will occur by a multi-disciplinary team to ensure family-centered care and comprehensive preventive screening is offered by primary care physician practices. Workshops are planned for the National Academy of Family Physicians (NAFP) and the Families First Conferences.

Future plans and the upcoming needs assessment are driven by the spring strategic planning session at which the following suggested changes were made:
3a. Pilot test with ACCESS Provider Network for eligible CYSHCN in Washoe county; increase access/primary care/medical home initiative
Type of service: Direct service

3b. Continue physician training for comprehensive screenings (including developmental and behavioral) and quick guide reminders, such as posters in the exam rooms of when age appropriate screens should occur.
Type of service: Enabling

3d. Expand Bright Futures initiative. Keeping Nevada updates included on the online curriculum and approaching primary care providers statewide.
Type of service: Infrastructure Building

3g. (1k.) Coordinate all age appropriate screening under umbrella approaches such as medical home, well child/EPSDT and educate families to seek comprehensive preventive exams and how to pay for services.
Type of service: population-based

3h Identify opportunities and expand collaborations to continue development of Nevada's Electronic Birth Registry (EBR) for the purpose of enhanced tracking and data collection.
Type of service: Infrastructure Building

c. Plan for the Coming Year

Collaboration with Medicaid Service Provider will continue for training to providers on regular screenings within the medical home. Ensuring all rural providers are educated on the comprehensive screenings for their population.
Continue opportnities to enhance the Nevada Electronic Birth Registry for improved tracking and data collection.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	60	62	64	54	60
Annual Indicator	55.4	55.4	53.5	53.5	53.5
Numerator					
Denominator					
Data Source				2006 Natl Study	2006 Natl Study
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	62	66	70	75	75

Notes - 2009
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)
Increased the target objectives to be inline with national average of 62.0% (2006 data)

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)
Increased the target objectives to be inline with national average of 62.0% (2006 data)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
CSHCN staff assists families applying for Medicaid and Nevada Checkup (SCHIP) by providing information and referral to appropriate programs for which they are eligible. CSHCN staff review applications and direct families to programs that will benefit them the most and the CSHCN program will continue to provide benefits to families of CSHCN while waiting for enrolment in Medicaid or Nevada Check Up. CSHCN staff in Las Vegas, Carson City and Elko, continue to distribute document organizers to assist families of CSHCN when applying for public assistance and to reduce stress when completing multiple applications. This document organizer is available in English and Spanish. The Nevada Advisory Council will continue to explore the possibilities of a universal on-line application for all health coverage programs. The CSHCN program has Spanish speaking staff in both Carson City and Las Vegas to assist Hispanic families with applications, either by phone or in person, to direct them to the proper program. CSHCN applications are available in both English and Spanish. In addition the program also has an employee in Elko who has a great outreach to the Native American population. The regional Elko Resources for Children website lists rural services and how to obtain their services.
The Bureau will continue to work with the Catalyst Center and Family TIES to enhance funding for family centered wrap-around services increase enrolment and retention in Medicaid and Nevada Check-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Per the national CSHCN survey, 55.4% of Nevada families have adequate private and/or public insurance to pay for the services they need. Partnerships with Great Basin Primary Care are underway.				X
2. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources.		X		
3. CSHCN staff provided advocacy for families with private insurance by providing medical information (especially for rare disorders), in order to justify the need and coverage for specific services and supplies.		X		X
4. The MCH information line, CSHCN helpline, and the CSHCN program continues as a referral source for Medicaid and Nevada Check Up, as well as for SSI for CSHCN.		X		X
5. Staff continued to address the issues raised during the town hall meetings on Medical Home (Dr. John Reiss, TA last year). Staff attended the Nevada Association of Family Physicians conference and engage spokespersons for medical home and Healthy Kid				X
6. The first draft of the Nevada Birth Outcomes Monitoring system was completed (formerly the Birth Defect registry) with complete CY 2005 and 2006 pooled data.		X		X
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN staff will consider new ways to work with the Access to Healthcare Network which provides an alternative means of obtaining healthcare for individuals who are uninsured and fall within certain income guidelines. Two Reno hospitals and nearly 50 doctors are part of this network. The only qualifications for this program are: must be currently uninsured, must show proof of Nevada residency (such as a bill or rental agreement; legal status is not considered), must have a picture ID, must show proof of income and fall within income guidelines.

The advocacy role of the Nevada Advisory Council for CYSHCN is increasing. They and the MCH Advisory Board are working with Medicaid and Nevada Check Up to improve access for public coverage. MCH staff are working with organizations involved in the health reform initiatives to support increased access/coverage for MCH populations.
Future plans and the upcoming needs assessment are driven by the spring strategic planning session at which the following suggested changes were made:
Increase Access to care (based on CYSHCN Needs Assessment) by the following:

3b. Get ‘read only' rights for NOMADS by CSHCN financial assist. Specialist; increased access/care coordination/enhanced referrals
Type of service: Infrastructure building, enabling

3c. Support for FASD outreach

c. Plan for the Coming Year

Staff have worked to increase knowledge of resources for healthcare services. The needs assessment will include discussion on resources available and needed.
The development of care coordiantion in the communities for children with special ehalth care needs will continue to address the needs of children for services. The knowledge of the family resource centers of the community will assist families in gaining access and knowledge fo available resources and how to navigate the processes to obtain services.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	82	80	83	85
Annual Indicator	75.1	75.1	82.6	82.6	82.6
Numerator					
Denominator					
Data Source				2006 Natl Study	2006 Natl Study
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	93	95	97	97

Notes - 2009
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)
Increased the target objectives to be inline with national average of 89.0% (2006 data)

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)
Increased the target objectives to be inline with national average of 89.0% (2006 data)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Program staff continue to cross-refer with Nevada 2-1-1 and partner with coalitions and organizations that provide training, information and emotional support. Individuals and their families identified through the Birth Outcome Monitoring System (formerly the Birth Defect Registry) will continue to be provided with an informational letter about the CSHCN program. This provides them with a point of contact where they can be directed to the most beneficial program depending on eligibility.

This year, program staff would like to take a more active role in coordinating the community-

based organizations working towards a Universal Online Application. Also, if a broad base of financial supporters for Nevada 2-1-1 could be developed and Nevada 2-1-1 could assist families twenty-four hours a day, 7 days a week, then Nevada 2-1-1 would qualify for national certification and federal funding. CSHCN staff would also like to strengthen the collaboration with Aging and Disability Resource Centers (ADRC) Family TIES and the Strategic Planning Accountability Committee (SPAC) to improve the intake process for public assistance programs. In addition, the Bureau would like to work more closely with Great Basin Primary Care, Child Health Policy, and Kids Count to customize data collection. Collaboration with the Aging and Disability Resource Centers as a "no Wrong Door" approach so CSHCN and their families could obtain application assistance.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Per the national CSHCN survey, 75.1% of families report the community-based service systems are organized so they can use them easily. MCH contracts with the statewide Nevada 2-1-1 system in hopes to expand to a 24 hour 7 day a week system.		X		X
2. CSHCN staff continued to assist families in applying for Medicaid and Nevada Check Up by providing information and referral to appropriate programs and community resources.		X		
3. The MCH information line continues to be a primary component for signing up infants and children for Medicaid and Nevada Check Up. All callers were queried regarding their insurance status.		X		X
4. The Elko regional workgroup has received funding for expanded outreach for CSHCN in the northeast rural and frontier areas of the state. Their regional resource website has english and spanish resources.				X
5. The CSHCN program will work with Nevada Medicaid and Nevada Check Up to increase the number and tracking capacity of CSHCN who receive an EPSDT, or "well child" examination for their child.		X		X
6. The Children with Special Healthcare Needs 2005 Survey indicated that 82.6% of those interviewed said the community-based service systems were orgnaized and could be used easily as compared to the 2000 survey of 75.1%. Staff and the council continue				X
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN staff, ACCESS provider network, Covering Kids and Families, and the Strategic Planning Accountability Committee for persons with disability are teaming to pilot an online application tool (modeled after Utah Clicks!). The new HRSA Systems Transformation grant addresses issues of concern to families about how they access services and difficulties maintaining a medical home. Changes within the MCH block grant structure will ease up some funding for new subgrants to enhance community-based services, and offer more bilingual services.

5a. Simplify the complex application process.

The CYSHCN Helpline will be contracted to the community-based Family Voices organization. This will greatly improve the family-centered care component and increase the depth of

referrals/support given.
Nevada 2-1-1 is a strong partner and is being added to most outreach materials. The Nevada 2-1-1 website is continually monitored by Project Assist staff to assure services related to CYSHCN needs are listed and accurate.
The Link Up Nevada project is working with primary care offices to provide non-medical referrals via a fax referral form. Websites among Title V, Family TIES, the Nevada Academy of Family Physicians are now linked with well child and parent support resources.

c. Plan for the Coming Year
Working with the CYSHCN Advisory Council and the MCH Advisory Board staff will strengthen collaboation with ADRC, Family TIES and Early Intervention Services. One project is to improve the intake processes.
The Nevada Advisory Council for CYSHCN will be reviewing and updating their strategic plan in the coming year and addressing their survey and reviewing needs assessment information to address needs.
MCH is working to provide more frequent reports on data trends for specific populations with interpretation.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11	12	17	42	45
Annual Indicator	5.8	5.8	41.7	41.7	41.7
Numerator					
Denominator					
Data Source				2006 Natl Study	2006 Natl Study
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	55	60	65	65

Notes - 2009
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)

NOTE: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern

revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Increased the target objectives to be inline with national average of 41.2% (2006 data)

Notes - 2008
This is data from the SLAITS, National CYSHCN study, 2006 (conducted once every 5 years)

NOTE: Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Increased the target objectives to be inline with national average of 41.2% (2006 data)

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
CSHCN program staff will continue to assist eligible families to enroll in public assistance programs that will best address their financial needs and provide information on advocacy services for support and social needs. Youth transition to adulthood will continue to be a priority of the Nevada Advisory Council for CSHCN. CSHCN staff will better coordinate with the Department of Employment, Training and Rehabilitation to address CSHCN youth health transition to adulthood. The Bureau of Family Health Services has partnered with Family TIES of Nevada, Inc. (an affiliate of Family voices) and received a three-year HRSA grant for the project "Link Up Nevada". Family TIES of Nevada with support from CSHCN staff will begin to address the frustration youth have with barriers to receiving health care for their CSHCN and non-health support services, and the lack of attention to the transition needs for youth with disabilities and special health care needs. Youth mentors will be hired in rural locations to aid youth and families with young CSHCN to begin the transition process early. These mentors will be beacons of hope for a successful transition. In addition, the Bureau of Family Health Services is partnering with Family TIES to enhance their on-line training center. This will provide valuable training to health professionals and families who cannot attend the face-to-face workshops.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN program staff counsel parents and youth aging out of the program and assist with referral to adult health care providers.		X		
2. CSHCN program staff provide information for families and youth aging out of the program regarding the change in funding streams for adults.	X	X		
3. CSHCN program staff provide family information regarding IEP for appropriate vocational training of CSHCN.	X	X		

4. CSHCN program staff encourage families to be involved with the educational plan for their child.	X	X		
5. PCP and families are given information on adult providers to work with specific conditions.	X	X		
6. PCP and families are given information where community ancillary services may be available.	X	X		
7. The CSHCN systems change team will support the youth health transitioning activities under the new HRSA grant.				X
8.				
9.				
10.				

b. Current Activities
In our MCH technical assistance work with Dr. John Reiss, we will build upon the transition activities designed and tested at the University of Florida. Some of the Florida materials developed may be customized for use in Nevada. CSHCN staff will continue to partner with Nevada 2-1-1, Family TIES, and Nevada PEP to assure youth can locate the services they need.

Future plans and the upcoming needs assessment are driven by the spring strategic planning session at which the following suggested changes were made:
Increase Access:
6a. Increase partnering network to become involved in proposed Medical Home and Youth Transitioning work 2008-2011
6b. (2d.) Coordinate with DETR and InterAgency Transition Board for Youth Health Transitioning work

Link Up Nevada (HRSA Systems Transformation Grant) is devoted to Medical Home and youth Health Transitioning. MCH Staff are supporing Family TIES (Nevada Family Voices organization) with their state wide project. They have newly hired youth mentors, are planning a youth health transitioning summit for December 2009 and are meeting regulary with technical assistance- Dr. John Reiss.

c. Plan for the Coming Year
The CYSHCN Advisory Council will be working on their strategic plan and needs assessment and an identified area of focus is transitioning of chidlren with special health care needs. Staff are communicating with Medicaid to work on expanidng eligibility requirements such as aging out for young adults.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	70	72	67	69
Annual Indicator	66.7	69.3	50.0	45.9	47.1
Numerator			37176	34110	35652
Denominator			74316	74382	75705
Data Source				NV Immunization Program	NV Immunization Program

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	71	72	74	74

Notes - 2009
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward, leaving out parts of children's immunization records.

Notes - 2008
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records.

CDC National Immunization Survey NIS data July 2007 – June 2008
variable 4:3:1:3:3:1†††

Numerator & Denominator information is not available per this survey.

Notes - 2007
These numbers only represent the number of children aged 19-35 months in each designated year who are in the registry. These percentages are lower than the NIS rates. This can be explained by providers using the registry and only entering vaccinations from a certain date forward leaving out parts of children's immunization records.

This data is from "Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Local Area. U.S. National Immunization Survey, Q3/2006 - Q2/2007

a. Last Year's Accomplishments
H1N1: The Immunization Program was included, and played an active role in, the Nevada State Health Division's response to the Novel H1N1 outbreak.
The immunization registry working with the Nevada Birth registry to initiate a medical record at birth will make tracking a child in Nevada and ensuring up to date immunization possible. This link will also provide needed ongoing data for determining needs in Nevada.
MCH staff have worked closely with IZ staff in planning and implmentation of our common goals. Working with our communities and legislators around numerous bill drafts that address childhood health our relationships have strengthed.
Implement registry statute NRS 439.265 adopted by 2007 Legislature and registry regulations adopted at June 20, 2008. The new law and regulation go into effect on July 1, 2009. Efforts continue on provider education, training and marketing plan.

Efforts to expand to northern Nevada education to the WIC clinic staff on the importance of immunization. Staff are trained by local partners and one incentive is an annual awards dinner where WIC clinics are honored for their acheivements.

The immunization coalitions have been invited to the Maternal Child Health Advisory Board as a standing invite. The coalitions have been working with Title V staff to plan and present a Early Childhood Summit that addresses many MCH issues. The summit is in September 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to educate healthcare professionals on immunization mandates, schedules and efficacy	X			
2. Continue efforts on linkages of the Immunization Information Registry to the Nevada Birth Records				X
3. Continue to improve Immunization Registry laws to promote use and data entry for improved recordkeeping and tracking of immunizations				X
4. Continue work coaltions and community groups to identify and resolve health issues on barriers to immunizations			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Improve immunization systems and infrastructure through use of ARRA stimulus grant funds.

• Review, enhance and improve WebIZ infrastructure.

• Upload data from SNHD; develop data sync every 72 hours importing SNHD data into statewide Nevada WebIZ. Troubleshoot and improve data upload with SNHD to complete statewide registry and reduce duplicates created.

• Develop and implement opt-in and opt-out procedures. Currently, children are opt-out and adults are opt-in. Therefore, separate disclosures for children and adults will be needed effective July 1, 2009. Regulation changes per BOH will allow for children and adults to be treated the same as opt-out.

• Develop and implement Countermeasure Response Administration (CRA) pan flu module in WebIZ.

• Develop and implement de-dup process; process to prevent creation of duplicates.

• Explore the development of HL7 messaging or flat-file interface with HMOs/Health Plans in order to populate the registry with historical data.

• Develop and implement GIS mapping project to determine geographical areas in Nevada that have low immunization rates.

• Input historical (legacy) data into WebIZ to increase the number of complete immunization records.

• Connect the State of Nevada, Electronic Birth Registry System to WebIZ. This connection will establish an immunization record into the registry upon a child's birth in Nevada.

c. Plan for the Coming Year

The Immunization Registry is the focus. We are currently working to bolster the registry with the HL7 interface capabilities so that the IZ system will be able to communicate with provider electronic medical record systems to alleviate the double entry into the registry. The Immunization Program also added into state NAC code the mandate that every immunization administered to child or adult must be entered into the registry. Finally, we have hired a cadre of contractual data entry folks who will be entering legacy data for providers so that we can capture

the history on their patients. Providers will enter going forward but the law does not require legacy data. These activities combined should decrease record scattering and begin to show a true picture of where gaps are in the state.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	26	25	25	24	24
Annual Indicator	26.4	26.7	26.4	25.7	25.7
Numerator	1353	1429	1465	1440	1440
Denominator	51274	53593	55520	55942	55942
Data Source				Vital Stats	Vital Stats
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	23	23	23	23	23

Notes - 2009
The data is preliminary and will be available in December of 2010.

2008 data was entered for 2009.

Population data is interim from the state demographer. The numerator is preliminary.

Notes - 2008
Population data is interim from the state demographer. The numerator is preliminary.

Notes - 2007
Population data is interim from the state demographer. The numerator is preliminary.

a. Last Year's Accomplishments
The Nevada State Health Division has entered into a new $45,000 subgrant with the Nevada Broadcaster's Association to produce and air abstinence education messages. In order to build the capacity of youth-serving organizations to implement positive youth development efforts to encourage adolescents to delay sexual activity, the Abstinence Education program is also subgranting to Community Chest, Inc. to provide technical and administrative support to the Nevada Youth Action Council (formerly the Governor's Youth Advisory Council) which includes abstinence education messages. The Health Division also funded the Crisis Pregnancy Center to support the Worth the Wait Program. The Teen Pregnancy Prevention subcommittee of the Maternal Child Health Coalition of Northern Nevada conducted several activities in Washoe County as part of Teen Pregnancy Prevention month.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Continue to support community-based education			X	
2. Continue to support an educational media campaign			X	
3. Provide resources and information for services through our community partners and our information and referral line.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Congress has not passed legislation to extend authority and funding for the Section 510 Title V State Abstinence Education Grant Program (AEGP) so this grant will end on June 30, 2009. The loss of abstinence education program funding also means the loss of funding in Nevada to support statewide teen pregnancy prevention efforts because historically, Nevada's Abstinence Education Program has been the only program funding within the Health Division to specifically address preventing teen pregnancy. The Division will have to identify other sources of funding to support its teen pregnancy prevention efforts. Planning for future teen pregnancy prevention efforts is pending the receipt of information regarding the allocation of future federal funding.

c. Plan for the Coming Year

The Nevada State Health Division, MCH program in collaboration with community partners continues the First Time Motherhood/ New Parents campaign which develops and implements innovative media outreach and education to this population on resources in Clark County. Clark County is the largest urban county in NV with over 73% of the states population. Linked to our MCH campaign through out statewide information and referral service, NV 211, further resources are advertised through this mechanism.

Outreach continues to address access and information on a broad scope for perinatal services through our MCH Advisory Board's subcommittee, Access to Perinatal care. This group addresses issues of the flu epidemic, healthcare coverage and gaps, direct care issues and social services support. Work with a youth action council will work to address the teenage population and develop media for the teen mothers and new parent population

A Adolescent Health committee will be formed to address this population's health issues.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	38	40	42	44	38
Annual Indicator	33.0	41.0	41	37.5	37.5
Numerator	10350	13109			
Denominator	31364	31973			
Data Source				BSS 2006	BSS 2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38	40	40	40	40

Notes - 2009
The Denominator is 34,320.

Oral Health Surveys are not conducted every year. The 2004 and 2005 numerator is from the 2003 Basic Screening Survey (BSS). The 2006 numerator is from the oral health survey that was conducted in that year. The 2007 numerator is from the 2006 survey. The 2008-2009 numerator is from the survey conducted in those years. For the 2006 survey the dominator for the 2004-2005 school year was used. For the 2008-2009 survey the dominator for the school year 2006-2007 was used. The dominator numbers provided above are the number of third graders enrolled in the school year 2004-2005, 2006-2007 and 2008-2009 in Nevada based on a report that the Department of Education provides.

Notes - 2008
The denominator is 34,320.

Oral Health Surveys are not conducted every year. The 2004 and 2005 numerator is from the 2003 Basic Screening Survey (BSS). The 2006 numerator is from the oral health survey that was conducted in that year. The 2007 numerator is from the 2006 survey. The 2008-2009 numerator is from the survey conducted in those years. For the 2006 survey the dominator for the 2004-2005 school year was used.

For the 2008-2009 survey the dominator for the school year 2006-2007 was used. The dominator numbers provided above are the number of third graders enrolled in the school year 2004-2005, 2006-2007 and 2008-2009 in Nevada based on a report that the Department of Education provides.

This data is based on a statewide screening of children enrolled in third grade conducted in 2006. Children were not resurveyed in fiscal year 2008. The 2008 figure reported is an estimate based on the 2006 survey results and uses the Nevada Department of Education's Public and Private School Enrollment figures for third graders during the 2007-2008 school year.

Future objectives expected to decline. (The Annual Performance Objective goals for future years on this Performance Measure were adjusted downward following the loss of HRSA funding supporting two of Nevada's three school-based dental sealant programs. It is anticipated that the obtainment of new funding for the larger of the two programs, Seal Nevada South, will allow this indicator to improve and meet or surpass earlier levels.)

Notes - 2007
The denominator is 34,234.

Oral Health Surveys are not conducted every year. The 2004 and 2005 numerator is from the 2003 Basic Screening Survey (BSS). The 2006 numerator is from the oral health survey that was conducted in that year. The 2007 numerator is from the 2006 survey. The 2008-2009 numerator is from the survey conducted in those years. For the 2006 survey the dominator for the 2004-2005 school year was used.

For the 2008-2009 survey the dominator for the school year 2006-2007 was used. The dominator numbers provided above are the number of third graders enrolled in the school year 2004-2005,

2006-2007 and 2008-2009 in Nevada based on a report that the Department of Education provides.

a. Last Year's Accomplishments

In May 2009, the Oral Health Program entered into a subgrant with CCOH to support a .5 FTE Dental Sealant/Coalition Coordinator. This has allowed CCOH to re-build the Seal Nevada South program. The Coordinator provides technical assistance and program support, including the submission of grant applications and reports. The Coordinator and an MPH intern, who is currently completing a practicum with the Bureau, are in the process of finalizing a State Dental Sealant Plan. The plan will be used to guide expansion of existing and implementation of new dental sealant programs within our state.

During Nevada's 2009 legislative session a bill was introduced by oral health stakeholders to have the State Oral Health Program recognized in statute. The bill passed unanimously by both houses and was signed by the Governor on April 22, 2009. This action as well as having the Oral Health Program Manager position budgeted into the MCH grant helps to build sustainability into the OHP and strengthens their capacity to provide the support needed to reach this performance measure.

Nevada's OHP conducted the open mouth survey of Nevada's third graders during the 2008-2009 school year. Preliminary findings show a decrease in the number of students with one or more dental sealants from 41 percent in 2006 to an estimated current rate of 38.5 percent. The change is due to loss of HRSA funding and the resulting closure of two of Nevada's three school-based sealant programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to collaborate with and provide technical support to Saint Mary's, Community Coalition for Oral Health, UNLV School of Dental Medicine, and the College of Southern Nevada on school-based dental sealant programs.				X
2. Continue to provide technical support for school-based dental sealant program planning, implementation, and evaluation.				X
3. Promote sealant placement by Medicaid and Nevada Check Up providers and by the private practice community.			X	
4. Ensure continued support for sealant programs by funding the Oral Health Program Manager position with MCH Block Grant funds.				X
5. Continue to collect, analyze and report data on sealants.				X
6. Provide train-the-trainer and in-service training on oral health screening and appropriate referral to community health and school nurses, and other health care providers.		X		
7. Offer oral health education for healthcare providers and families of Children with Special Health Care Needs.		X		
8. Utilize data to identify disparities in access to dental disease prevention services including dental sealants.				X
9. Coordinate outreach of community and school-based dental sealant programs to reduce duplication, address gaps and reach target populations.				X
10.				

b. Current Activities

It is hoped that identification of new funding for the Seal Nevada South program and the concerted effort on their rebuilding will reverse this downturn and ultimately surpass the 2006 rates. The final surveillance report will be completed and disseminated during federal fiscal year 2009.

During 2009 the OHP finalized their bi-annual Burden of Oral Disease report. This report summarizes the most current information available on the oral disease burden of people in Nevada. When available, comparisons are made with national data and the Healthy People 2010 goals. The Burden of Oral Disease in Nevada -- 2008 also attempts to identify racial/ethnic, socio-economic as well as geographic discrepancies in disease prevalence and disparities in access to oral disease prevention and treatment resources.

Nevada's oral health stakeholders have used earlier versions of these reports to apply for additional funding, evaluate local program impacts and plan and prioritize statewide, regional and individual program activities. When final versions of OHP reports are approved, they are published to our website at: http://health.nv.gov/CC_OH_Publications.htm

Utilizing findings from the recently completed surveillance of Nevada's third graders and guided by Nevada's Statewide Dental Sealant Plan the OHP will solicit input from Nevada's oral health leaders to address gaps in access, strengthen existing programs and identify and support new community and/or school-based sealant programs.

The OHP als

c. Plan for the Coming Year

The OHP also intends to continue to support the .5 FTE Sealant/Coalition Coordinator position through the subgrant with CCOH. The scope of work includes tracking sealant program activities, identifying new funding opportunities and supporting program development.

The OHP will continue offering community and health care provider education on the benefits and potential public health cost savings of providing dental sealant services. The program will also provide technical assistance with data collection and evaluation of existing programs.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.4	2.3	2.2	2
Annual Indicator	4.6	4.7	2.5	2.3	2.3
Numerator	24	26	14	13	13
Denominator	526084	549579	569703	573966	573966
Data Source				ICD 9 codes-Cause of Death	ICD 9 codes-Cause of Death
Check this box if you cannot report the numerator because 1.There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2	1.9	1.9	1.9	1.9

Notes - 2009
Data entered is from 2008. The data will be available in December, 2010.

Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

Notes - 2008
Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

Notes - 2007
Please note: FARS only collects data on traffic way related fatalities.
These numbers do not include private property, parking lots or off road.

a. Last Year's Accomplishments
The Injury Prevention Program (IPP) will continue to be involved in the Nevada Executive Committee on Traffic Safety, which been created, and formalized meeting several times a year. The goal is to address highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies committed to improving highway safety. The IPP will continue an active role in the Child Passenger Safety Task Force, organized by the Nevada Office of Traffic Safety Office. Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue collaboration on motor vehicle crash prevention efforts throughout the State. The IPP will continue to collaborate with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Nevada Office of Traffic Safety. The IPP will look for continued opportunities to get their name out in public forums to increase awareness of child deaths caused by mother vehicle crashes, and push for tougher legislative reform, such as a mandatory seatbelt law in Nevada. The IPP will continue to collect, analyze and report on motor vehicle crash data. Provide motor vehicle crash data to local communities and stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Program performs data surveillance on Motor Vehicle Crashes of children aged 14 years and younger.				X
2. The Injury Prevention Program will look for ways to help partners in funding their childhood motor vehicle prevention efforts.				X
3. The Injury Prevention Program is actively involved in the Nevada Highway Strategic Safety Plan (SHSP), the Seat Belt CEA Team, and the Nevada's Executive Committee on Traffic Safety. The goal is to address highway safety in a comprehensive and coord				X
4. The Injury Prevention Program is also involved in the Child Passenger Safety Task Force, which is a result of a			X	X

recommendation made in the Occupant Protection for Children Assessment, and is organized by the Nevada Office of Traffic Safety. The purp				
5. The Injury Prevention Program is collaborating with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, the Nevada Department of Public Safety, and the Office of Traffic Safety.			X	
6. Motor vehicle crashes continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue collaboration on motor vehicle crash prevention efforts throughout the State.			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Injury Prevention Program continued involvement in the Nevada Executive Committee on Traffic Safety, meeting several times a year. Addressing highway safety in a comprehensive and coordinated manner that will involve a variety of federal, state, and local agencies committed to improving highway safety.

The Injury Prevention Program continued involvement in the Child Passenger Safety Task Force, organized by the Nevada Office of Traffic Safety Office. Provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.

The Injury Prevention Program plans continued involvement in the Emergency medical Services for Children Advisory Committee.

Motor vehicle crashes continued to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue collaboration efforts regarding motor vehicle crash prevention efforts throughout the State.

The Injury Prevention Program continued collaboration with the Nevada Department of Transportation, Nevada Department of Motor Vehicles, Nevada Department of Public Safety, and the Nevada Office of Traffic Safety.

c. Plan for the Coming Year

The Injury Prevention Program will be continuing to collect, analyze and disseminate reports on motor vehicle crash data. Providing data to local communities and stakeholders.

The Injury Prevention Program will work with Washoe County Safe Kids program to develop activities around infant and child safety, such as providing children with special health care needs car seats, infant safe sleeping campaings, and reducing accidental poisoning in adolescents.

The Injury Prevention Program is seeking to provide mini grants for activities to injury prevention partners.

The Injury Prevention Program in collaboration with MCH and the Statewide Child Review Team are planning a injury prevention conference for 2011.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		25	27	32	27
Annual Indicator	22.7	23	26.5	25.1	25.6
Numerator					

Denominator					
Data Source				PedNSS	PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	29	30	31	31

Notes - 2009
NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extrated from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistancy in the report.

Perf. Obj. This was a new reporting measure in 2005. Progress toward the projected objectives are not met. A review for more realistic objectives were made this year. This is a new program, had major organizational shifting, new staff and activities are underway but need time to get a foothold for outcome indicators to change greatly.

This is just WIC data, Nevada has no other way to capture rates at the infant's 6 month mark. We can ask WIC for it directly, or we can get it from the federal agencies that they send it to: PedNSS. CDC, through the National Immunization Survey, produces a breastfeeding report card for each state that includes process and outcomes indicators.
http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm
CDC through their National Immunization survey conducts it annually.

CDC is by the entire state, we should be able to get clinic data directly from Nevada WIC Program, could be possible to run a report by zip code.
HP 2010 Objective 16-19b, increase to 50% (Baseline: 29% in 1998)

Notes - 2008
NV WIC Program is the only source of breastfeeding data available in the State. The NV WIC program sends the raw data extrated from their MIS to the PedNSS at the CDC. The CDC processes the data and reports back only the percentages, NV WIC program does not know the value of numerator and denominator used. Currently, the MIS uses regional parameters to calculate programatic indicators that are not fully compatible with CDC's, thus the MCH uses the PedNSS data to ensure consistancy in the report.

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CDC through their National Immunization survey conducts it annually.

CDC is by the entire state, we should be able to get clinic data directly from Nevada WIC Program, could be possible to run a report by zip code.
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Notes - 2007
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a. Last Year's Accomplishments
The Breastfeeding Program made much progress during FY 09. In addition to the WIC Breastfeeding Coordinator, a Statewide Breastfeeding Coordinator position was created and filled, which is paid 50% from the MCH Block Grant and 50% from WIC. This combined funding source allows the position to not only improve breastfeeding rates among WIC participants, but to also improve breastfeeding rates in the general Nevada population. The Statewide Breastfeeding Program completed the following: applied for and received a grant from the Office on Women's Health to develop a worksite lactation education and community support program for working mothers breastfeeding their baby, and an award program to recognize the efforts of employers who support these working mothers, purchased breastfeeding books that were distributed to every public library, OB/GYN, Pediatrician, La Leche League Group, and WIC Clinic in Nevada, offered three different breastfeeding trainings, two of which were CLC trainings. We had 70 people from across the state complete these courses, including WIC staff and nurses, and 30 Multi-User Electric Breast Pumps were purchased for the University Medical Center (UMC) NICU in Las Vegas. Previously, NICU moms were given manual breast pumps to pumps their breast milk, which is not sustainable. This purchase has already tripled the number of NICU babies receiving breast milk at UMC. The Statewide Breastfeeding Program is now playing an active leadership role in the Breastfeeding Task Force of Nevada. The program is organizing all quarterly meetings and maintaining the website, and it created a Breastfeeding Room in the Health Division's main office building. This room is for Health Division employees to use while pumping breast milk when they are away from their babies. The room is private, secure and includes a breast pump, mini-refrigerator, and comfortable chair. The Coordinator is also working the Human Resources Department to expand this service to other state offices. The Nevada WIC Program started a new breast pump program by ordering Single User Electric Breast Pumps for WIC participants that meet certain requirements. They also ordered additional Multi-User Electric Breast Pumps and manual breast pumps. These three types of breast pumps were distributed to all WIC Clinics across the state. The Nevada WIC Program updated all policies and procedures surrounding breastfeeding promotion and education.
The Nevada WIC Program continued to support and expand the breastfeeding peer counseling program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to offer different breastfeeding trainings, including CLC trainings to WIC staff and nurses across the state.		X		
2. Support any breastfeeding specialist/advocate to take the IBCLC exam				X
3. Continue to lead and support the Breastfeeding Task Force of Nevada (BFTN).				X
4. Assist the BFTN to conduct an Ethics Training to be held for				X

physicians across the state.				
5. Work with State Human Resources Departments to implement worksite lactation support in all state office buildings.			X	
6. Encourage all labor and delivery hospitals in NV to move towards becoming a Baby-Friendly hospital.				X
7. Work with partners to include breastfeeding curriculum in Nevada nursing and medical school curriculum.				X
8. The State BF Coordinator will gain clinical hours needed to be eligible to take the IBCLC exam.				X
9.				
10.				

b. Current Activities

The Statewide Breastfeeding Program made huge strides this year and built many relationships across the state. The program completed the following: created and will distribute 5,000 Nevada breastfeeding 2010 calendars using pictures of Nevada moms and babies, ordered and distributed three types of breast pumps and other breastfeeding accessories to all WIC clinics, revised WIC's breastfeeding policies and procedures, expanded the peer counseling program, held activities for World Breastfeeding Week, created a new breastfeeding logo and served as a resource for other employers who created lactation rooms at their business.

The Statewide Breastfeeding Program continued to lead and support the Breastfeeding Task Force of Nevada by working with the Task Force to implement the goals and objectives of a mini-grant they received from the United States Breastfeeding Committee (USBC) for an Ethics in Breastfeeding Training to be held for physicians across the state. The Breastfeeding Program also took the lead on another Task Force mini-grant that was received from HRSA called the Business Case for Breastfeeding. This grant allowed the Task Force to give out over twenty $300 stipends to help businesses with the expenses associated with creating lactation rooms.

c. Plan for the Coming Year

The Statewide Breastfeeding Program will continue to offer different breastfeeding trainings, including CLC trainings, to WIC staff, nurses and interested community members across the state. Two 45-hour trainings are scheduled this year: one in Northern Nevada and one in Las Vegas. The program will also encourage and support any breastfeeding advocate to sit for the IBCLC exam. The Nevada WIC Program will create an atmosphere to make breastfeeding promotion and support and priority for all WIC clinics. The Statewide Breastfeeding Program will continue to lead and support the Breastfeeding Task Force of Nevada in any way possible, as well as help build the local breastfeeding coalitions in Northern, Southern and rural Nevada.

The Statewide Breastfeeding Program has plans to create a statewide breastfeeding website, which will serve as a resource for anything to do with breastfeeding in Nevada. There are also plans to create and distribute a 2011 breastfeeding calendar, continue to work with the state Human Resources Department to implement worksite lactation support in all state office buildings, will build relationships with Nevada hospitals and encourage them to adopt breastfeeding friendly practices. Some more progressive hospitals will be encouraged to meet the requirements to become Baby Friendly, which includes staff training on breastfeeding for physicians and nurses. The Program will work to include lactation information in the Nevada nursing schools and medical school curriculum, will work to improve statewide data collection surrounding breastfeeding. The Statewide Breastfeeding Coordinator will gain the clinical hours needed for her to be eligible to take the exam to become an International Board Certified Lactation Consultant. Plans to implement the Health Care Reform bill that will require employees to provide a lactation location for mothers are underway and the Statewide Breastfeeding Program will assist in this transition by providing education and support.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	95	97	97	99	99
Annual Indicator	96.2	96.7	98.8	99.2	99.0
Numerator	35116	37834	38744	38232	36372
Denominator	36485	39122	39209	38541	36747
Data Source				EHDI database	EHDI database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
From the state Newborn Hearing Database
EDHI manager

a. Last Year's Accomplishments
The Nevada EHDI Program worked on a number of issues. One of the most difficult issues for the program to address was the shortage of audiologists in Southern Nevada. This results in delays in diagnosis, increased loss to follow-up and creates frustration for parents and healthcare providers. In order to address the issue the program workied in three areas; working to decrease the hospital referral rate to decrease the burden on audiologists, working with audiology programs around the nation to recruit audiologists to Nevada, and working with audiologists currently in Southern Nevada to expand their practice to include pediatric patients. The Nevada EHDI Program plans to continue the development and implementation of the EHDI database to allow for the tracking and follow-up for referred infants. The program worked with non-profit organizations around the state including Hands and Voices, the Deaf and Hard of Hearing Advocacy Resource Center and A.G. Bell to create cooperation and unity around hearing loss issues and create a system of referral for parents of children that have been identified with hearing loss. The Program also worked to receive an additional HRSA grant to focus on reducing loss to follow-up within the state. funds focused on the hiring of a contract audiologist that will be responsible for educating hospital screeners and nursing staff, and helping develop audiology capacity in Southern Nevada.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Nevada Newborn Hearing Screening program screens 98.8% of infants born in the State.			X	

2. Families with infants who were referred for further hearing evaluation post hospital discharge are directly referred to Nevada Early Intervention Services.		X		X
3. The Newborn Hearing Screening program works with Early Intervention Services to encourage follow up evaluation for hearing and speech and language developmental assessment.		X		X
4. The Newborn Hearing Screening program works with CSHCN to offer families assistance with accessing needed services.	X			
5. The Newborn Hearing Screening program maintains a 'registry'' of children who were referred for further hearing evaluation.			X	X
6. Staff have begun working with the National Initiatives for Children's Healthcare Quality (NICHQ) Learning Collaborative to identify issues and implement change.			X	X
7. A web-based tracking database has been purchased and is being developed meet the needs of the program.			X	X
8.				
9.				
10.				

b. Current Activities

the Nevada EHDI Program plans to continue development through the expansion of staff to provide data entry and reminder phone calls to parents of referred infants. Staff is utilized as Help Desk Personnel for the EHDI database. Program staff began active recruitment for audiologist from graduate programs around the nation. Restricted in travel to graduate programs to provide information booths and distribute literature, the program advertised in professional journals and includes providing flyers and literature to a number of graduate programs. The program plans to work with Nevada Hands and Voices to develop the Guide by Your Side Program which will work to shuttle families through the EHDI Process and provide education and advocacy for families of children identified with hearing loss. The Nevada EHDI Program is expanding marketing activities around the program. This includes development of new brochures, posters and promotional activities, and targeting materials to ensure maximum effectiveness. grant funding will provide hiring a contract audiologist to educate hospital screeners in best practices and appropriate referral, and work to train audiologists in pediatric techniques.

c. Plan for the Coming Year

The EDHI program will continue efforts to provide education to hospitals on hearing screening and services available statewide. Hiring of an audiologist to travel to hospitals is under way. The audiologist on staff are working to track and follow up with infants who do not pass their screening. This will include building relationships with hospitals to provide direct referrals to audiologists.

On December 14, 2009 a Nevada Hearing Conference will be held to provide information on hearing loss issues to parents and professionals.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	18	17	17	16	14
Annual Indicator	18.6	17.9	18.8	16.9	16.9
Numerator			122018	128670	128670

Denominator			648797	763309	763309
Data Source				GBPCA 2009 Rpt	GBPCA 2009 Rpt
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14	13	13	12	12

Notes - 2008
Data is from the Great Basin Primary CAre Association 2009 report
http://www.gbpca.org/uninsured/Docs09/Uninsured_Report_09.pdf

Notes - 2007
2007 indicator is from the U.S. Bureau Current Population Survey 2007 (new source of data for 2007)

a. Last Year's Accomplishments
BCFCW staff l facilitated and mobilized Great Basin Primary Care, Covering Kids and Families, and the state Primary Care Development Center to partner and present a shared message raising awareness about the severe shortage of providers in the state of Nevada. Community organizations report instances of willing providers who move from another state, pay $2,500 for the licensing process, are denied licensing (lose the fee) and move back out of the state. Policy changes are needed for reciprocal licensing and to address other barriers to practicing in Nevada.

The Physician Associations engaged to accurately describe the additional support needed to retain the practicing medical providers in the state. The J1 program is on track and no abuse of the system occurred. Retention in Nevada's underserved programs remains high.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Bureau will continue to support the expansion of Nevada Check Up				X
2. Continue to prepare the data needed for designations for HPSAs, MUPS and MUAs				X
3. The MCH Information and Referral Line will continue to refer to Medicaid and Nevada Check Up		X		
4. The Maternal and Child Health Advisory Board will continue to have updates from Medicaid and Nevada Check Up and encourage their expansion.		X		
5. Continue the EPSDT workgroups to ensure Medicaid coverage of all needed services for children.		X		
6. Develop a way to take a more active role in coordinating the community based organizations who are working toward a Universal Online Application.		X		
7. staff will facilitate and mobilize Great Basin Primary Care, Covering Kids and Families, and the state Primary Care				X

Development Center to form a united front and shared message to raise awareness about the severe shortage of providers in the st				
8.				
9.				
10.				

b. Current Activities
Redesign of the CYSHCN program to possible discounted insurance program. This will enable uninsured to receive reduced fee coverage and access to primary care/medical home as has not occurred with the prior model.

The Primary Care Office is advocating for policy changes to improve the provider ratio in Nevada. Recent legislation is shortening the time for out-of-state providers to become licensed to practice in Nevada. The PCO has contracted a position to set up a database linking licenses with providers databases. This will create a more accurate list and count of providers practicing in Nevada. Prior lists were inflated. Data will be updated annually now and presented on a map so providers can be identified by geographic regions. The information will be available by census tract.

New provider training curriculums are being developed to orient new J1 physicians and their employers.

MCH Staff are involved in Community Health Worker training and volunteer network with Area Health Education Centers. The staff and Advisory Board are also working with Covering Kids & Families to apply for the new CHIPRA grants (The grants will help support President Obama's work to ensure millions of currently uninsured children across the country get the health care they need.)

c. Plan for the Coming Year
MCH Staff are involved in Community Health Worker training and volunteer network with Area Health Education Centers. The staff and Advisory Board are also working with Covering Kids & Families to apply for the new CHIPRA grants (The grants will help support President Obama's work to ensure millions of currently uninsured children across the country get the health care they need.)

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15	14.5	11	11
Annual Indicator	15.8	15	12.6	13.8	14.8
Numerator					
Denominator					
Data Source				PedNSS tables	PedNSS tables
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	9	9	9

Notes - 2009
Using the 2009 Pediatric Nutrition Surveillance
Nevada Summary of Demographic Indicators Children Aged <5 Years
Table 2C

Notes - 2008
Using the 2008 Pediatric Nutrition Surveillance
Nevada Summary of Demographic Indicators Children Aged <5 Years
Table 2C

Notes - 2007
This data is from the Centers for Disease Control Pediatric Nutrition Surveillance System for WIC. It is reported as 85% - 95% and >95%. What is reported here is the > 95% rate.

a. Last Year's Accomplishments
Nevada State Health Division's WIC Nutrition Education Coordinator is now certified by the American Dietetic Association in Childhood and Adolescent Weight Management. This training and learned expertise will guide the development of training for all WIC Local Agency staff in 2010.
In preparation for the new WIC Food Package (details in Plan for Coming Year) the State WIC Program has started an educational campaign with clients entitled "Mooooove Over to Reduced Fat Milk" and is targeting families with 2-5 year old children.
Lastly, the State WIC Program developed and distributed activity classes to the local agencies to help them promote indoor activities within WIC families. (Let's Have a Ball, Bowling Game and Ball in the Basket)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Train local WIC Agency staff to perform motivational interviewing and participant centered education				X
2. Provide training to local WIC Agency staff, physicians and stores around the new WIC Food Package				X
3. Use the Fruits and Veggies More Matters logo and brand to help market increased fruit and vegetable intake among WIC families.			X	
4. Continue the educational marketing campaign of "Mooooooove over to reduced-fat milk" through WIC clinics targeting 2-5 year old WIC children.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
VENA -- Nevada WIC Program is striving to train the local agency staff to perform motivational interviewing and participant-led behavioral decision-making. Basically, a shift from "speaking to the eligibility code" to "speaking to the family" and assessing readiness for change.

New WIC Food Package - The new WIC food package will begin October 1, 2009 and should be much more compatible with decreasing childhood obesity. The new food package will include fruits and vegetables, only allow low-fat milk, include whole grain and provide less juice, cheese and eggs. This is a huge change and will hopefully result in big improvements on the growth grids for Nevada's overweight WIC kids. In addition, the Nevada WIC Program intends to use the Fruits and Veggies More Matters ™ as the marketing message for the new WIC Food Package that includes fruits and vegetables.

The NV WIC Program is also partnering with the Nevada SNAP Partner Network (State Nutrition Action Plan) to promote breakfast.

c. Plan for the Coming Year
In FY 09, we have expanded efforts around VENA (Value Enhanced Nutrition Assessment) to help facilitate participant centered education through comprehensive training efforts that encourage staff to utilize participant centered education techniques to promote behavior change.

The State Agency developed a series of Nutrition Education lesson plans which are centered upon the facilitated discussion model in efforts to enhance participant education and interaction. Of the lesson plans developed, there are two which target children between the ages of 2-5 years old; Let's Have a Ball focuses on the benefits of interactive play; and Social Butterflies focuses on teaching social skills through play. In FY 09, the State Agency trained local agencies on using the facilitated discussion style, and on using the new lesson plans. Again, new in FY 09, a new partnership was developed between Sesame Street and Nevada WIC to introduce Sesame's newest nutrition education initiative aimed at children 2-5 in efforts to help reinforce proper diet and sound nutrition decision making skills for a lifetime. The Sesame Street Healthy Habits for Life initiative was introduced in select Local Agency's as an effort to address the needs for nutrition and exercise education amongst this age group.

In efforts to encourage proper meal planning, the State Agency made available in all clinics a set of food models to help staff communicate to participants the importance of proper proportions in meal planning.

As nutrition education around obesity prevention and education has become a priority nationwide, Nevada WIC is also committed to this need at the request of WIC staff Statewide, the annual Statewide Training in September 2010 will feature a nationally recognized expert on the topics of nutrition education and obesity in WIC.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		7	6	6	5
Annual Indicator	7.6	7.0	6.6	5.9	6.1
Numerator	2771	2738	2727	2286	2264

Denominator	36479	39260	41175	38777	36847
Data Source				vital stat/birth cert	vital stat/birth cert
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	4	4	4	4

Notes - 2009
Data for women who smoked in the last three months of pregnancy is unavailable. Data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

Data for 2009 is preliminary. Data will be finalized in March 2011.

Notes - 2008
Data for women who smoked in the last three months of pregnancy is unavailable. Data consists of women who smoked at any time during their pregnancy (numerator) and the number of women who gave birth (denominator).

Data for 2008 is preliminary. Data will be finalized in December 2010.

a. Last Year's Accomplishments
Based on data from Nevada Interactive Health Data Base, the number of pregnant women who smoked between the ages of 15 and 30 is approximately 9 percent for the state of Nevada. However, the rate of women who smoke during pregnancy in the rural and frontier areas of Nevada, have a prevalence rate that is twice the state average. NV's activities include Tobacco Brief Intervention(TBI) workshops, a four hour training conducted by Dr. Sher Todd of Operation Tobacco Free Babies that provides the behavioral interviewing skills for health professionals to conduct the 5 A's at every encounter: Ask, Advise, Assess, Assist, and Arrange TBI was conducted for all Community Health nurses (20) in the state to provide them with the skills to engage with their pregnant, smoking clients. In April 2009, 1800 letters and smoking cessation tool kits were sent out to physicians across the state encouraging them to advise their smoking patients to quit. Operation Tobacco Free Babies is a program which is funded by Master Settlement dollars, where Dr. Sher Todd offers tobacco cessation counseling and referral to all pregnant women who arrive for prenatal care. Dr. Todd not only counsels the pregnant woman but the whole family on the risks of tobacco use, secondhand and third-hand smoke. This program has been in operation for at least 4 years.

Southern Nevada Health District screens all of their prenatal clients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate the training of all local agency WIC Staff on the Tobacco Brief Intervention techniques, partnering with Nevada		X		X

Tobacco Free Babies Project (Dr. Sher Todd)				
2. Continue to support and fund local health districts Tobacco Cessation and Prevention efforts through NV's CDC Tobacco funds, including prenatal clients.				X
3. Continue to advertise the NV QUIT-line throughout the state.			X	
4. Coordinate with the State Prenatal Substance Abuse Prevention Coordinator to improve data collection for this measure.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NSHD increased collaboration between the CDC Tobacco Prevention and Education Program and the State WIC Program. Through this new line of communication, Nevada Tobacco Free Babies Project (Dr. Sher Todd) trained local WIC agencies in the Brief Intervention techniques, (explained previously) TBI conducted for all WIC staff across the state(approximately 200) to enable them to advise and refer their pregnant, smoking clients. Nevada passed legislation that will braid the MSA Tobacco dollars to the CDC Tobacco Prevention and Education Program, and planning for this local lead agency initiative in SY 2010. Whenever possible, emphasis on tobacco cessation for pregnant and lactating women will be emphasized, increasing the impact of this performance measure.

Under the Prenatal Substance Abuse program is the 4Ps Pregnancy screening that includes tobacco use data that will be useful. The project has screened more than 2,000 women in northern Nevada in 2009 and collaboration of this data with the CDC Tobacco program and MCH Staff will definitely occur.

Additionally, other smaller data sets will be incorporated into the assessment and evaluation pieces of the performance measure. The Substance Abuse, Prevention and Treatment Agency (SAPTA) database does record pregnant women and smoking information, limited to women in treatment programs. Also the Birth Defect Registry records smoking, but this is a small population size.

c. Plan for the Coming Year

MCH is working on a Pregnancy Risk and Monitoring Surveillance pilot, this information will assist in identifiying behaviors and attitudes of pregnant women and new mothers on smoking during pregnancy and birth outcomes. Tracking these sources, however specific and/or small, will add to the total picture of pregnant women and smoking in Nevada.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14	7	6	6	5
Annual Indicator	14.1	11.8	7.8	4.6	4.6

Numerator	25	22	15	9	9
Denominator	177850	185872	192576	194035	194035
Data Source				vital stats/ death cert	vital stats/ death cert
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	5

Notes - 2009
Data entered is from 2008. Data will be available in December, 2010.

ICD-10 codes X60-X84, Y87.0 and U03 listed in the underlying cause of death were used to compile the data.

Notes - 2008
ICD-10 codes X60-X84, Y87.0 and U03 listed in the underlying cause of death were used to compile the data.

This data is preliminary. The data will be available in December, 2010.

a. Last Year's Accomplishments
The Injury Prevention Program collaborated with the Nevada Office of Suicide Prevention and other key partners paying particular attention to youth suicides. In addition the Office of Suicide Prevention was added as a member agency on Nevada's Injury Prevention Task Force.
The Injury Biostatistician continued to collect and analyze suicide data for the State of Nevada.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Program performs data surveillance on suicides throughout the State of Nevada. A 'Snapshot on Suicide' was published.				X
2. The Injury Prevention Program continues collaboration with the Nevada Office of Suicide Prevention and other key partners paying particular attention to youth suicides.			X	
3. Suicides continue to be a priority of Nevada's Injury Prevention Task Force. The Task Force members will continue collaboration on suicide prevention efforts, especially youth suicides throughout the State.			X	
4. The Primary Care Development Center will continue to designate Mental Health HPSAs, MUPS and MU.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
The Injury Prevention Program collaborated with the Nevada Office of Suicide Prevention and other key partners paying particular attention to youth suicides. In addition the Office of Suicide Prevention was added as a member agency on Nevada's Injury Prevention Task Force.
The Injury Biostatistician continued to collect and analyze suicide data for the State of Nevada.

c. Plan for the Coming Year
The attempted and completed suicide rate in Nevada remains one of the worst in the nation. A 'Snapshot on Suicide' has been published by the Injury Prevention Biostatistician after conducting analysis of the most current suicide data available. All suicide data analyzed and published are shared with the Nevada Office of Suicide Prevention, other key stakeholders, and made available on the Nevada State Health Division website.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	97	97	97
Annual Indicator	95.2	94.7	93.2	72.9	75.1
Numerator	455	515	497	357	341
Denominator	478	544	533	490	454
Data Source				vital stats/ birth certs	vital stats/ birth certs
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	99	99	99

Notes - 2009
Data greater than or equal to 2008 included level 3 only. Data for 2009 is preliminary. Data will be available in March, 2011.

Notes - 2008
Data greater than or equal to 2008 included level 3 only. Data for 2008 is preliminary. Data will be available in December, 2010.

Notes - 2007
Data less than or equal to 2007 included level 2 and level 3.

a. Last Year's Accomplishments

All activities with the MCH Campaign continue. The southern health districts implemented the Nurse Family Partnership initiative to first time mothers which address the need for prenatal care in these women. Nurse Family Partnership model programs are evidence based. The model in the south has had much success with over 80 women giving birth to full term babies. These women were some of the youngest in the nation using this model.

The Bureau and the Health Division will continue to partner with organizations to address the issue of prenatal care to improve birth outcomes and to provide prenatal care to the communities in greatest need.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue outreach and public awareness to available prenatal services		X	X	
2. Work with coalitions and community partners to identify and resolve barriers to early access to prenatal care		X		X
3. Continue to collect, analyze and report on birth outcomes to community groups, coalitions and stakeholders				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

continued work on the First Time Motherhood/New Parents grant collaboration with our community partner. This initiative includes public awareness around early access to prenatal care and where these services are located. The media campaign has begun and the MCH campaign contract includes providng numbers of women who saw the media campaign and called NV 211 for resources.

Title V staff continue to build relationships with providers through the Nevada Chapter of the American Academy of Pediatrics, Academy of Family Practitioners and the Nevada Hospital Association. Title V provide information, resources and support to these organizations.

Within the Health Division Title V staff work with the Bureau of Licensing and Certification (BLC)to ensure facilities are up to date on policy and practice. IN the coming year Title V will expand its outreach to BLC by providng education on MCH related practices such as Newborn Screening and Newborn Hearing. Reaching providers through area health education centers will be reviewed as a means of continuing education to healthcare professionals.

Our MCH campaign line will move to our statewide toll-free information and referral line, Nevada 211 .This will offer expanded hours and resources to our populations.

c. Plan for the Coming Year

Access to prenatal care committee from the MCHAB was formed in early 2010 and addresses issues of perinatal health.

Support from Title V funding will be expanded to a diverse population based service that will include education, outreach, training and evaluation.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	74	76	78	80
Annual Indicator	67.2	64.3	64.7	69.4	59.4
Numerator	25032	25721	26621	26914	21875
Denominator	37259	40006	41175	38777	36847
Data Source				vital stats/ birth certs	vital stats/ birth certs
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	85	85	85	85

Notes - 2009
Data for 2009 is preliminary. Data will be available in March, 2011.

Notes - 2008
Data for 2008 is preliminary. Data will be available in December, 2010.

Notes - 2007
Data is preliminary and will be available in December, 2010.

a. Last Year's Accomplishments
Efforts continued on development of a southern MCH coalition of local healthcare providers, businesses, and organizations to form an alliance towards the goal of maternal and women's health issues including increasing early access to prenatal care throughout our state.
The northern Nevada MCH coalition, which partners with diverse community partners and our Health Division, is focusing on prenatal awareness and education.
Discussions on measures to improve the number of pregnant women receiving prenatal care in the first trimester focused on a need for improving physician reciprocity, legislative changes to nursing regulations regarding midwives, and working with the university system to develop mid-level practitioners. A state mandate that would provide presumptive eligibility through Medicaid did not pass through our legislative session. Our communities state that waiting for Medicaid eligibility is a barrier to early access to prenatal care. Our coalitions are addressing this issue and will work with stakeholders.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue outreach and public awareness to available prenatal services		X	X	

2. Work with coalitions and community partners to identify and resolve barriers to early access to prenatal care		X		X
3. Continue to collect, analyze and report on birth outcomes to community groups, coalitions and stakeholders				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Our MCH campaign line ws moved to our statewide toll-free information and referral line. This expanded the access and scope of the MCH line. MCH provides outreach and awareness on this transition. MCH staff worked with communities on outreach and the most effective method to reach our populations. Through focus group and key informant interviews with the First Time Motherhood Grant, we have learned communities most trust community partners. MCH will use communites to reach the population and assist in development of the messaging. Community driven strategies that are evidence based will be supported by MCH and have shown to reduce infant mortality and low birth weight babies.

Title V staff will continue to work with the MCH Advisory Board to address issues of access to prenatal care. The board will implement lessons learned from technical assistance received from MCHB last year. Title V staff have been designated to work with members of the MCHAB to assist with any needs in regards to MCH related issues. This relationship has improved our communication with our board members. Title V subject matter experts have worked with board members to address focus areas in a smaller workgroup which allows for an effective means of communication that is later shared with the larger group. The board members provide guidance on their subject matter to the Title V staff.

c. Plan for the Coming Year

Plans for the coming year include continued communication with MCHAB and work to further build the coaltions in the north and south. Our north and south coaltions have attended local, state and national events on MCH activities which will assist in building their infrastructure and their capacity to address MCH issues.
Communication through their websites and conferences held by the coaltions and our First Time Motherhood grant to assist in outreach and education throughout the state.
Promotion of our MCH information and referral line will be enhanced and will include innovative messaging such as text.
The Access to Prenatal committee are working on a survey of women who presented in the emergency rooms of Clark County hospitals with no prenatal care will be done in 2010. Also the Pregnancy Risk and Monitoring Surveillance pilot will give state specific data on barriers to prenatal care that will be valuable in building programs and addressing these issues.
Work will continue with our health districts througout Nevada and other providers in outreach and education on receiving prenatal care. Work with teenagers will be a focus area.

D. State Performance Measures

State Performance Measure 1: *Increase the percent of women of child-bearing age who receive screening and assistance for domestic violence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	15	15	15
Annual Indicator	5.7	6.0	5.6	3.9	3.9
Numerator	30288	30015	28982	19546	19546
Denominator	528027	498297	515208	503840	503840
Data Source				Title V contract pgms	Title V contract pgms
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	15	15	

Notes - 2008
Data from Title V funded pregnancy clinics and Nevada Network Against Domestic Violence women aged 18-44years. Denominator is state demographers projection of women.

a. Last Year's Accomplishments
Building collaboration with organization on domestic violence prevention. Building relationship with child death review groups and injury prevention to address behaviors that lead to domestic violence and and reducing recidivism among families.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to partner and support efforts of statewide domestic violence prevention advocacy groups and organizations			X	
2. Continue to disseminate information and materials to coalitions, community groups and healthcare professionals			X	
3. Continue to serve on committees that offer education to healthcare professionals on screening women of child bearing age for domestic violence.			X	
4. Ensure screening of women of childbearing age in all Title V funded programs				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Staff continues to build collaborations with organizations . Staff partners with Nevada Network Against Domestic Violence to train healthcare professionals on domestic violence screening. Our MCH Campaign vendors will continue to screen for domestic violence for women who come in for prenatal care.
Primary prevention on preventing violence against women have partnered domestic violence, sexual assault prevention and injury groups. This collaboration shares resources and addresses commonalities in each target population.
Staff Provide technical assistance on performance measures to organizations on domestic

violence. Support the statewide domestic violence organization in its interventions and strategies on reducing domestic violence.

c. Plan for the Coming Year
Plans for the coming yar include working with youth organizations to address intimate partner violence. Work will include awareness, education and efforts to begin advocacy around sexual violence prevention with youth 18-24 trained on advocacy and the issues of sexual assault. Our prevention partner organizations of domestic violence, sexual assault, and injury will work with the Attorney General's office and continue to address issues such as bullying, sexting, and other issues that can have negative effects on our youth.

State Performance Measure 2: *Increase the rate of significant Medicaid dental providers to the Medicaid population of children, youth and pregnant women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		1.9	2	2	2.1
Annual Indicator	1.8	1.5	1.9	1.9	7.4
Numerator	298	344	422	405	392
Denominator	167271	235066	222530	212029	53284
Data Source				NV DHCFP	NV DHCFP
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.2	2.3	2.4	2.4	

Notes - 2009
Data is for federal fiscal year 2009.

Numerator
FFS Report from DSS. Reports from HMOs were combined with FFS report to obtain total paid overall to each dentist in Access.

Data was not requested from Anthem for the first quarter of the fiscal year.

Count of dentists paid more than $1,000 during the reporting year was calculated from the Access database.
Denominator
All Children: All members age 0-18 during the reporting period (by birthdate).

Women of Childbearing age: All female members age 15-44 during reporting period (by birthdate).
Note: Report counts all women 15-18 as children and does not duplicate them.

Notes - 2008
Data comes from the Nevada Division of Health Care Financing and Policy (DHCFP). The numerator is the number of dentists who received at least $1,000 in payments in the reporting year and the denominator is the number of Medicaid clients in the cohort. The reported number is the ratio of dentists per 1,000 population in the cohort.

a. Last Year's Accomplishments

The Nevada Division of Health Care Financing and Policy (DHCFP) continues to provide dental services in Clark and Washoe Counties using a managed care model and both Managed Care Organizations (MCO) contracted by the DHCFP continue to exceed the ratio of dentists to clients required by their contracts. The DHCFP implemented a new $600 a year annual cap on dental services for Nevada Check Up clients. In addition, it eliminated orthodontic coverage for these clients. However, the recently passed federal SCHIP legislation has required the DHCFP to reinstate these benefits.

All of the safety-net dental providers mentioned above continue to provide dental services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to collect, analyze and report data on the MCH population covered by Medicaid.				X
2. Continue to offer support to the Division of Health Care Financing and Policy around policy and recruitment issues.				X
3. Continue to provide support to the six regional oral health coalitions in Nevada.		X		X
4. Continue to disseminate information to stakeholders about dentists seeking to serve underserved populations.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Health Access Washoe County will be opening a new clinic in Virginia City which will include dental services. This will bring the number of dental clinics operated by HAWC to four (two in Reno, one in Silver Springs, and one in Virginia City).

c. Plan for the Coming Year
Plans for the coming year will include working with our Primary Care Office to bring more providers to Nevada.

State Performance Measure 3: *Decrease the percent of women, ages 18 to 44, who are obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		18	18	17	17
Annual Indicator	19.7	23.0	21.9	20.0	22.5
Numerator	104021	98268	94783	88875	101025
Denominator	528027	426760	433217	444805	448508
Data Source				BRFSS 2008	BRFSS 2009
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	16	16	16	16	

Notes - 2009
This data is from Nevada's preliminary 2009 BRFSS report.

Notes - 2008
This data is from Nevada's preliminary 2008 BRFSS report.

Notes - 2007
This data is from Nevada's preliminary 2007 BRFSS report.

a. Last Year's Accomplishments
The CSHCN Program nutritionist: provided education and counseling to parents with CSHCN; worked with Medicaid to start payment for Registered Dieticians in order to provide medical nutrition therapy for children through the Early Periodic Screening Diagnosis and Treatment program (EPSDT); worked with school nurses and lunch program to promote healthy lifestyles; worked with schools on the data collection for BMI data in the schools, 4, 7 and 10th grades.
All Nevada elementary school received supplies of the "Eagle Series" books on nutrition.
The Medical Consultant worked with statewide partners in addressing women's health issues throughout the lifespan and education the public on nutrition and physical activity.
Childcare Consultants (CCHC) were trained on nutrition and healthy menus for the child care setting. The CCHC's provided education to childcare providers and parents.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with Human Resource Departments, both public and private sector, providing technical assistance on implementation of worksite wellness initiatives, this also includes lactation support in the worksite.				X
2. Assist the WIC Program and the ITCN WIC Program in implementing the more healthful WIC Food package in Fall 2009.		X		
3. Continue to support local health districts' wellness initiatives.				X
4. Work with the Advisory Council for the State Program on Fitness and Wellness to showcase evidence-based wellness practices.				X
5. Continue to work to expand school and community gardens and Farmer's Markets throughout Nevada.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The nutritionist was the National Fruits and Vegetables Program Coordinator for Nevada. During the remainder of her time at the HD, she coordinated with the University of Reno Cooperative Extension, Action for Healthy Kids, schools, hospitals, and daycare centers, to train community organizations and distribute educational materials. The program supported the creation of safe routes for pedestrians and bicyclists to increase physical activity in communities across NV.
The Wellness Manager has been appointed to the Governor appointed Bicycle Board, and has been supporting Safe Routes to School, Pedestrian and Bicycle routes, along with providing input

on educational campaigns to increase these avenues of physical activity.
Childcare Consultants have continued providing education to parents and child care providers on nutrition and physical activity, along with screenings using the EPSDT.
The Bureau provides support for the local wellness initiatives in Southern Nevada, Washoe County and Carson City Health Districts. The Bureau has made strides in capturing women at work through an onsite fitness center, promoting the outdoor walking trail, promoting Women's Health Week, and supporting breastfeeding in the workplace. The state health insurance provider has begun providing educational presentations and quarterly newsletters on nutrition, physical activity, and wellness.
The Fitness and Wellness CoCouncil has made obesity in school aged children and worksites a priority.

c. Plan for the Coming Year
The Wellness Program Manager will continue working with the Bicycle Board and The Fitness and Wellness Council (FAWC) to increase physical activity avenues across the state; provide input on educational campaigns that will encourage physical activity and healthy eating; assist in the development and implementation of Worksite Wellness Best Practices for Nevada Employers; and assist the evaluation of the School Wellness Policy implementation to increase nutrition, physical activity, and wellness initiatives in the schools for students and staff.
The Fitness and Wellness Council website will be the home site for Nevada utilizing the theme "Get Healthy Nevada". The Get Healthy Washoe and Get Health Clark sites will be linked to the FAWC website. This website will house information and state resources that focus on Physical Activity, Nutrition, and Wellness for Communities, Worksites, Parents and Schools.
The state health insurance provider will continue working on worksite wellness initiatives for the State Employees. The Bureau will continue encouraging physical activity and nutrition at work with the on-site fitness center, outdoor walking trails, and offering healthy eating options at Bureau sponsored events.
It is the intention of the HD to develop online trainings on nutrition, physical activity and wellness for daycare providers, school personnel, and healthcare providers, in an effort to educate/train professionals that have regular contact with women.

State Performance Measure 6: *Decrease the percent of children and youth ages birth through 18 who die from unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		5	5	5	5
Annual Indicator	10.9	14.0	10.6	9.3	9.3
Numerator	73	98	77	68	68
Denominator	667830	697715	723176	728603	728603
Data Source				ICD10 codes	ICD10codes
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	5	5	5	

Notes - 2009
The data entered is from 2008. ICD codes were not available for 2009. The data is preliminary. Data will be available in December, 2010.

Notes - 2008

This question is for unintentional injuries only. ICD-10 codes V01-X59,
and Y85-Y86 listed as the underlying cause of death were used to compile the data.

The data is preliminary. The data will be available in December, 2010.

Notes - 2007
Data is preliminary and will be available in December, 2010.

This question is for unintentional injuries only. ICD-10 codes V01-X59,
and Y85-Y86 listed as the underlying cause of death were used to compile the data.

a. Last Year's Accomplishments
The Injury Prevention Program facilitated and injury Prevention Task Force providing guidance to the State with a goal of decreasing the number of childhood injuries and deaths.
The Injury Prevention Program was involved in the Child Passenger Safety Task Force. The purpose of the Task Force is to provide guidance to the State in decreasing the number of childhood injuries and deaths from motor vehicle crashes.
A half-time Biostatistician was employed by the Injury Prevention Program who was responsible for improving data collection and analysis of injuries in Nevada, including childhood injuries.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Injury Prevention Program continues to facilitate an Injury Prevention Task Force providing guidance to the State with a goal of decreasing the number of childhood injuries and deaths.			X	
2. The Injury Prevention Task Force members will continue collaboration on childhood prevention efforts throughout the State.			X	
3. The Injury Prevention Program continues to collaborate with coalitions committed to the prevention of childhood injuries throughout Nevada.			X	
4. The Injury Prevention Program continues to employ a half-time Biostatistician who is responsible for improving data collection, analysis, and dissemination of injuries in Nevada, including childhood injuries.				X
5. The Injury Prevention Program has and will continue support of the Cribs for Kids program with the goal of seeing it expand to other parts of Nevada.			X	
6. The Injury Prevention Program will continue to set aside monies to support the efforts of community partners involved in reducing injuries, disabilities, and deaths due to injuries in Nevada, including childhood injuries.			X	
7.				
8.				
9.				
10.				

b. Current Activities
The Injury Prevention Program continues its involvement in the Child Passenger Safety Task Force. The Injury Prevention Program has also become involved with the Nevada Emergency Medical Services for Children Advisory Committee, Administrative Team to Review the Death of Children, Children's Safety Network, as well as Safe Kids Washoe and Clark Counties.

The Injury Prevention Program continues to facilitate an Injury Prevention Task Force providing guidance to the State with a goal of decreasing the number of childhood injuries and deaths.
A half-time Biostatistician is employed by the Injury Prevention Program who is responsible for improving data collection, analysis, and dissemination of injuries in Nevada, including childhood injuries.
The Injury Prevention Program has worked with other state and local agencies to bring a pilot program of Cribs for Kids to the Northern Nevada area. This pilot program is targeting first time parents; providing them with both a safe sleep environment for their child and safe sleep education.
The Injury Prevention Program subgranted $38,500 out to community partners to help in the continued efforts to reduce injuries, disabilities, and deaths due to injuries in Nevada. Monies were awarded to groups focused on bicycle helmet safety, childhood drowning prevention and a special needs car seat program. Monies were awarded to two community partners in both Northern and Southern Nevada.

c. Plan for the Coming Year
The Injury Prevention Program will continue to collaborate with coalitions committed to the prevention of childhood injuries throughout Nevada. The Injury Prevention Program will continue to facilitate an Injury Prevention Task Force providing guidance to the State with a goal of decreasing the number of childhood injuries and deaths.
The Injury Prevention Program will continue to employ a half-time Biostatistician who will continue to be responsible for improving data collection, analysis, and dissemination of injuries in Nevada, including childhood injuries.
The Injury Prevention Program will continue support of the Cribs for kids Program with the goal of seeing it expand to other parts of Nevada.
The Injury Prevention Program will set aside monies to support the efforts of community partners involved in reducing injuries, disabilities, and deaths due to injuries in Nevada, including childhood injuries.
The Injury Prevention Program would like to look into prevention and data regarding teen related injuries, including accidental and intentional poisonings, as well as child abuse.

State Performance Measure 9: *Increase the number of schools (grades kindergarten to high school) that have access to a school based health center.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					10
Annual Indicator					
Numerator					
Denominator					
Data Source				CIS data	
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	15	15	20	

Notes - 2009
Will be reivised next yer.

Notes - 2008
This is a NEW performance measure and will have data next year. We project 10% increase in the number of school-based health centers (right now there are 7 in the state). Approximately 1.5

added per year to start. partner with Communities In Schools- Louise Helton for data

Two sources: Communities in Schools (http://cisnevada.org/) and Nevada Health Centers (http://www.nvrhc.org/sbhc.cfm) . These are the two main entities that run school based health centers in Nevada. The Nevada State College staffs the school based health center at Basic High School in Henderson.

Notes - 2007
Clark County is the only county in Nevada that has schools with SBHC. Currently only 3 elementary schools are equipped with these centers. We currenlty are awaiting for the # of children k-6 who are enrolled in school based heatlh centers (numerator). Some of these centers have only been in operation for 6 months because they were lacking medical directors. Therefore, we do not have reliable data to report for the numerator.

The denominator is 148,773. This data came from NV Annual Reports of Accountability provided by NV Dept of Education.

a. Last Year's Accomplishments
Nevada will change this performance measure in two ways: the percent of children who have access to a school based health center becomes simply the number of school based health centers, and secondly, the region isexpands to all of the counties in Nevada.

There are currently 6 school based health centers in Nevada,
3 in Las Vegas operated by the Federally Qualified Health Center, Nevada Health Centers (NVHC): CP Squires Elementary School, Roy Martin Middle School, and Valley High School, and 2 by Communities in Schools (CIS): Cunningham and Reynaldo Martinez Elementary Schools. There is also a SBHC at Basic High School in Henderson that is operated through grants and by the Nevada State College Nursing administration. Clark County School District, the fifth largest district in the United States, added a FTE in the District Office to facilitate the smooth operation of these facilities on their campuses, showing commitment and sustainability for the performance measure. All of Nevada's school-based health centers are based in southern Nevada.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical assistance and support to existing school-based health centers.				X
2. Provide technical assistance to Carson City School District to open a school based health center in 2009.				X
3. Invite Communities in Schools to address the Nevada Assocation of School Board Trustees at their annual conference in November 2009.				X
4. Send a Nevada Representative to the National Assembly of School Based Health Centers' annual conference for training.				X
5. Utilize existing Nevada kindergarten health parent survey data to drive the top health service priorities in each location of a school-based health center.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Communities in Schools of Southern Nevada plans to open 3 additional clinics in the Las Vegas area in the coming years. CIS feels that 6 clinics in the metropolitan Las Vegas area will provide coverage to all of the targeted/disparate populations. CIS has also expressed interest in expanding to Northern Nevada, with Carson City School District being the most likely school district to add the next clinic. In addition, Elko County School District will be approached by MCH Staff about the interest in a clinic at one of their Elko area schools. CIS will be invited to address the Nevada Association of School Board Trustees at their annual meeting in November. Nevada will look closely at the CDC's Coordinated School Health Program and move towards its' guidance to enhance its funding opportunities.

Carson City School District is now in the process of completing a needs assessment that includes surveying parents, staff, community members and middle/high school students.
The District Office has already committed the use of a modular building at its Eagle Valley Middle School, and CIS is interested in overseeing the operations of this clinic.

Data from the first and second years of a parent Kindergarten Health Survey will be used to see what health services are lacking as children enter into the school system. This information will be shared with our school based health center partners.

c. Plan for the Coming Year
We are awaitng information on this PM.

State Performance Measure 11: *Reduce the prevalence of Fetal Alcohol Spectrum Disorders (FASD).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective				35	32
Annual Indicator			346.7	463.2	
Numerator			26	63	
Denominator			75	136	
Data Source				Birth Outcomes Monitoring Data	*see notes
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	30	28	25	23	

Notes - 2009
Review of a performance measure that staff have the capacity to collect and shows efforts taking place in Nevada is under review. Therefore no data is available. Expect data collection and measure to be revised.

Notes - 2008
The initiative that started last year continued in the north. This represents a total year's data collected in northern Nevada and analyzed by Children's Research Triangle, Chicago.

Indicator should be .3467- program defaults to this number.

FASD is now refined into
FAS1 fetal alcohol syndrome
FAS3- partial FAS,

FAS5- ARND alcohol related neurological disorders

2008 includes Reno clinic, Clark clinic + EIS clinic FASD data

Notes - 2007
This initiative started May 19,2008. Data is for 6 weeks.
Indicator should be .3467- program defaults to this number.
Indicator is Reno-Mojave only.

a. Last Year's Accomplishments
Addressed the waiting list for children needing FASD diagnostic services at the University Of Nevada School Of Medicine (UNSOM), Las Vegas and began services in Reno. Implemented expansion at UNSOM and initiated services at Mojave Adult, Child and Family Services in Reno. Briefly, a total of 90 children were diagnosed; 60% of the children had some form of FASD, five children had full blown FAS, 31 children had Partial FAS (FAS 3), and 18 children with Alcohol Related Neurological Defects (ARND). and referred on to multiple services that included speech and physical therapy, child psychiatry, audiologist and geneticist.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen pregnant women for ATOD in partner clincs			X	
2. Provide education through the 4P's plus program			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
May 2008 marked the two-year anniversary of continued prevention efforts from the Perinatal substance Abuse Prevention Program (PSAP) in Reno to screen, diagnose and refer women to treatment when appropriate. More than 4500 women have been screened. The Nevada Health Division (NVHD) contracted with Children' Research Triangle (CRT) Executive Director Dr. Ira Chasnoff, a nationally leader in the field, to begin implementation of the 4Ps+ screening in Las Vegas as part of the statewide prevention effort. The summary of the data below has implications for where to focus prevention strategies.

c. Plan for the Coming Year
To revise the current SPM to accurately reflect capacity to collect meaningful prevention data.
To work with the PSAP subcommittee and community partners to develop outreach prevention strategies based on the 4ps+ data.

To continue to seek funding for the FAS diagnostic clinics in a number of avenues that includes collaboration with the PSAP subcommittee members to assist in the development of community partners in the private sector to provide funds for the clinics to restart ; meeting with Medicaid to discuss options with respect to restarting the FASD diagnostic clinics; ,collaboration with State Senator Carlton re the presentation of a white paper to the IFC on the cost savings that funding clinics represents and rsearching grant opportunities.

To collaborate with the University of Arizona, Pediatrics to implement a regional CDC FAS Surveillance five-year grant. Purpose is to ascertain information/data on the prevalence of FAS and FASD in Nevada and regionally.

To continue the statewide NSHD effort to screen for alcohol and other drugs and provide prevention education to pregnant women and women who are suspected of being pregnant In order to do this, a new contract with CRT will be needed for Las Vegas efforts. Travel and additional training to provider staff will be a shared responsibility of the PSAP and CRT Coordinators. Additionally, the establishments of protocols and processes to ensure that referrals for women for possible treatment services are operational so that they receive appropriate services and their babies have the best possible birth outcome. The PSAP Coordinator will continue to provide a leadership role with the 4Ps+ team as they formulate a strategy to collect data that links the 4Ps+ screening to birth outcome in collaboration with identified systems and community partners.

To continue to collaborate with SAPTA to include two additional questions to the CDC BRFSS questions on perinatal substance abuse and pregnancy.

State Performance Measure 12: *Increase the timeliness of Newborn Hearing Diagnosis to 3 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					10
Annual Indicator					70.7
Numerator					41
Denominator					58
Data Source				NB hearing database	NB hearing database
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	15	20	10	

Notes - 2008
This is a NEW performance measure. Will have data next year from the Newborn Hearing database

a. Last Year's Accomplishments
This is a new measure therefore information is not available.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate fax referral forms to hospital staff and increase their understanding of their process			X	
2. Hands & Voices outreach to families of newly screened newborns		X		
3. Quality Assurance and monitoring of the numbers screened with need for further followup				X

4. Policy development to increase the number of specialists in our state.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
compiled the newborn hearing screening follow-up data from 3 sources for babies born in 2009. The data is from Nevada Early Intervention Services in both Reno and Las Vegas, and from Nanci Campbell, a private practice audiologist in Carson City. In total, 58 babies who were born in 2009 and did not pass the newborn hearing screening were seen at these offices for diagnostic hearing testing. Of these 58 babies, 41 received a diagnosis (of either normal hearing or confirmed hearing loss) within 3 months of their hospital newborn hearing screen.

Please be aware that this is a very small group of infants compared to the total infants statewide who did not pass their hearing screening. In addition, this small group may not be a representative sample and these outcomes may not reflect those of the larger population of infants who did not pass their screening. The infants tracked in this data set were born at a small group of hospitals that provide direct referral to an audiologist for follow-up diagnostic hearing testing. Most hospitals do not provide this direct link to an audiologist. For hospitals that do not provide a direct referral to an audiologist, babies must often go through their pediatrician who then refers to an ENT physician who then refers to the audiologist. By adding these extra steps, the time to diagnosis is usually extended.

It may be important to make note that this limited data set may not be a representative sample and why in the future.

c. Plan for the Coming Year
When this data is collected next year for 2010 births, a much larger data set will be available and the percent of babies who receive a diagnosis within 3 months will likely decrease to reflect the timeframes that typically occur across the state.

State Performance Measure 13: *Increase the percentage of children screened for age-appropriate developmental skills and behavioral health levels.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective					15
Annual Indicator			0.7	0.6	0.9
Numerator			1047	928	1397
Denominator			156514	157688	157688
Data Source				EIS data	EIS data
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15	10	10	10	

Notes - 2009
2008 population was entered for 2009 population due to the state demographer's numbers being unavailable.

Notes - 2008
This is a NEW performance measure, will collect data from Early Intervention screening initiative

a. Last Year's Accomplishments
Providing developmental, behavioral and autism screenings for children 18 months to 60 months of age through community screening events and phone/email screening project.
• Developed and maintaining database program of children receiving developmental, behavioral and autism screenings.
• Researching online options for developmental and behavioral screening service.
• Researching funding options for online developmental and behavioral screening service.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with physician associations to increase awareness of availability of the screens				X
2. Work with Bright Futures Well Child Initiative to increase number of primary care who offer comprehensive well child (including developmental and behavioral screens).				X
3. Increase awareness and visibility of services providing next level of assessments for developmental and behavioral screens.		X		
4. Increase visibility of recommended periods of these screens to providers and parents.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Develop funding mechanism for online screening service. Online screenings have been attained at the Early Head Start centers and other locations. Others continue with paper and pencil screening tools. The ASQ remains the prevalent screening tool.
• Contract with publisher of online screening program to establish online screening program.
• Train community providers to use online screening program for children 6 months to 60 months of age.
• Collaborate with pediatrician and family physician professional organizations to orient and train staff to use online developmental and behavioral screening service.
• Collaborate with pediatrician and family physician professional organizations to provide coding guidance for appropriate billing of developmental and behavioral screenings of young children.
Community professionals, school districts and parents have been trained in screenings.

c. Plan for the Coming Year
Plans for the coming year are to increase screening training to child care centers.
In jUne 2009 Assembly Bill 359 was enacted which requires teh boards of trustees to ensure that

certain personnel possess teh skills and qualifications necessary to work with pupils with autism. The bill further requries the health Divison to ensure that certain personnel possess the skills and qualifications necessary to provide services to children with autism and their families. This bill further emphasizes the need for training of professionals, parents, schools and child care centers.

State Performance Measure 14: *Decrease the percentage of at-risk for overweight and overweight children in Nevada public schools.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					22
Annual Indicator			23.2	23.2	24.4
Numerator					476
Denominator					1951
Data Source				YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	22	22	22	22	

Notes - 2009
YRBS is done every other year, thus data for 2009 is available in CY 2010.

The performance measure on the block grant form reads "Decrease the percentage of at-risk for overweight and overweight children in Nevada." we believe it should read "…overweight and obese….."

The YRBS survey at: http://apps.nccd.cdc.gov/youthonline/App/Default.aspx gives percentages and total respondents (the denominator) so you can determine the numerator by multiplying the percent times the total respondents.

Over weight = 13.4 percent and the denominator is 1,951;
The numerator is .134 X 1,951 = 261.4
Obese = 11.0% with the same denominator - 1,951.
The numerator is .110 X 1,951 = 214.6

Adding the two numerators together = 214.6 +261.4 = 476

Therefore, to fill out the block grant form we used 476 as the numerator and 1951 as the denominator and the percent will automatically be calculated at (476 / 1951) X100 = 24.4%

Notes - 2008
State Performance Measure #14
Data for 2008 is not available because the YRBS is done every other year. Data for 2009 will be available in CY 2010.

A) AB354 passed in 2007 requiring "each school district shall conduct examinations of height and weight of a representative sample of pupils in at least one grade of the:
(a) Elementary schools within the school district;
(b) Middle schools or junior high schools within the school district; and
(c) High schools within the school district,"
NSHD's Chief Biostatician, Alicia Hanson, is responsible for computing BMI and compiling school district data. This data collection is done annually. In 2007-2008, 4th, 7th and 10th grades were sampled.

B) Related, the Youth Risk Behavior Survey asks about how survey takers feel about their weight and health habits related to trying to lose weight.

a. Last Year's Accomplishments

Nevada's Advisory Council for the State Program on Fitness and Wellness sponsored registration and travel for 75 school nurses to attend the National School Nurses' Association's School Nurse Childhood Obesity Prevention and Education (known as SCOPE) training in Las Vegas in April 2009. The Council also paid for the development of a children's "Fit for Life" web page that will provide education and resources to Nevada's students. The MCH RD worked with the NV Department of Transportation and the NV Superintendent's Association to increase the number of school district's that applied for Safe Routes to Schools monies from NDOT.
Many schools in Clark County hosted family fitness and nutrition nights events to set the stage for parental involvement in school wellness Councils and parental involvement in providing healthy foods for their children and making physical activity a family a priority.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Wellness Section Manager will attend the CDC's BEAT Institute training around the built environment, including schools				X
2. Develop and provide comprehensive training to every school wellness coordinator in Nevada. Plans include 5 modules and monitoring of the web-based training.		X		X
3. Continue to support the training and resource needs of Nevada Public School Nurses.		X		X
4. Work with the Alliance for a Healthier Generation on school-based wellness and prevention initiatives.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH Nutritionist attended the CDC's BEAT Institute (Built Environment Assessment Training) in June 2009. Working closely with local school district staff, she will be able to articulate the needed changes to the built school environment as it relates to nutrition and physical activity in SY 2010.

UNLV Sports Education Leadership, NV's State Superintendents' Association and NV's Action for Health Kids are working cooperatively to provide training to every School Wellness Coordinator (650 total). National experts will be brought to Nevada, videotaped by the Las Vegas PBS Station, and 650 CDs were made and distributed. NAFHK provided personal follow-up and tracking Based on feedback provided by the Nevada school superintendents, the training was delivered using electronic and web-based technology. The trainings conceptualized as 5 sequential 50 minute modules. Based on the known reticence of school personnel and administrators to dedicate scarce resources and time to health and wellness, modules 1, 2, and 3 have been conceptualized with the need to increase knowledge and persuade school policy makers that an investment in a child's health is an investment.

c. Plan for the Coming Year

Once the Nevada Healthy School project develops the training modules, there must be a way to allow easy registration, evaluation and tracking of the schools' wellness progress.
Proposed: Website
This site could be housed in the Department of Education, Health and Human Services or outsourced to third party such as Nevada Action for Healthy Kids/National Action for Healthy Kids.
• Register school, school administrator and wellness coordinator
• Insure training modules are completed
• House method for Wellness Coordinators to log progress for evaluation purposes.

E. Health Status Indicators

Introduction

/2010/ The Health Status Indicators are a small portion of the data the Heath Division collects through the Center for Health Data and Research. Data plays a clear role in soliciting grants, building programs, assisting partners in obtaining funding, and evaluation through all Bureau programs. The Bureau strives to identify best practices that have been evaluated and use them to the state's advantage, with ongoing evaluation to ensure efforts are on track. In this coming year, the Health Division is moving to more population based initiatives, and working more closely with the state's three health districts. //2010////2011//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.3	8.3	8.2	8.0	8.0
Numerator	3083	3335	3391	3112	2950
Denominator	37259	40006	41175	38777	36847
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data for 2009 is preliminary. Data will be available in March 2011.

Notes - 2008

Data for 2008 is preliminary. Data will be available in December 2010.

Narrative:

The Bureau promotes early and continuous prenatal care to reduce low birth weight infants born in Nevada. Efforts continue through our MCH information and referral line, direct services and outreach and education with Medicaid, service providers and public and private organizations in 2009 and 2010. The MCHAB prenatal submittee is working on policy development, new initiatives and data to promote effective prenatal campaigns.

All of our perinatal activities focus on early access to prenatal care. In addition it is a priority for our MCHAB and our coalitions, and health districts.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.3	6.4	6.5	6.3	6.4
Numerator	2360	2488	2597	2375	2309
Denominator	37259	38756	39895	37597	35811
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data for 2009 is preliminary. Data will be available in March 2011.

Notes - 2008
Data for 2008 is preliminary. Data will be available in December 2010.

Narrative:
The Bureau promotes early and continuous prenatal care to reduce low birth weight infants born in Nevada. This data is derived from birth certificates. Initiatives discussed in HSI # 01 A also address this HSI. Along with initiatives already mentioned in HSI # 01A, the Southern Nevada Health District has implemented the Nurse Family Partnership for first time mothers. The Bureau continues to partner with this and other initiatives to promote healthy birth outcomes.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.3	1.4	1.3	1.3	1.2
Numerator	478	544	533	490	454
Denominator	37259	40006	41175	38777	36847
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data for 2009 is preliminary. Data will be available in March 2011.

Notes - 2008

Data for 2008 is preliminary. Data will be available in December 2010.

Narrative:
//2011//As with other HSI around birth weights, MCH works with our partners to improve early access to prenatal care, our information and referral line, and our committees to address the barriers to care.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.0	1.0	1.1	1.0	1.0
Numerator	365	397	420	363	362
Denominator	37259	38756	39895	37597	35811
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data for 2009 is preliminary. Data will be available in March 2011.

Notes - 2008
Data for 2008 is preliminary. Data will be available in December 2010.

Narrative:
/2010/ This data is from birth certificates. Initiatives noted in HSI # 01A address this indicator. Other initiatives described in the National Performance Measures demonstrate the Bureau's move to be more community-based, working with community partners to promote early entry into prenatal care, developing mid-level practitioners, and the First Time Motherhood/New Parents initiative. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9.3	11.1	10.0	8.4	8.4
Numerator	49	61	57	48	48
Denominator	526084	549579	569703	573966	573966
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
ICD10 Codes are not available at this time for 2009. Data entered was for 2008. The data may be available later in December 2010.

Notes - 2008
Data is preliminary, data will be available December 2010. ICD-10 codes V01-X59 and Y85-86 listed as the underlying cause of death were used to compile the data.

Notes - 2007
Data is preliminary, data will be available December 2010. ICD-10 codes V01-X59 and Y85-86 listed as the underlying cause of death were used to compile the data.

Narrative:
//2011// As discussed in NPM 10 and SPM 16.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.6	3.3	2.3	2.4	2.4
Numerator	24	18	13	14	14
Denominator	526084	549579	569703	573966	573966
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
ICD10 Codes are not available at this time for 2009. Data was entered from 2008. The data may be available later in December 2010.

Notes - 2008
Data is preliminary, data will be available in December 2010.

Motor vehicle (traffic related) ICD-10 codes V02-V04 (.1,.9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8) and V89.2 listed as the underlying cause of death were used to compile the data.

Notes - 2007
Data is preliminary, data will be available in December 2010.

Motor vehicle (traffic related) ICD-10 codes V02-V04 (.1,.9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8) and V89.2 listed as the underlying cause of death were used to compile the data.

Narrative:
/2010/ This data is from Vital Statistics, death certificates and Child & Family Services. As part of the Child Death Review Administrative Team, the members have worked with the Department of Public Safety to develop campaigns to promote healthy driving. The Injury Prevention surveillance has provided data to help target these campaigns. A campaign called "Click it or Ticket" promoted the use of seat belts. The Administrative Team evaluates each death and with the participation of the Attorney General identifies those areas where state law could be changed or newly enacted to prevent child deaths. For example, the Team worked with partners and identified legislators to change Nevada driver's license law to a graduated driver's license for adolescents. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.4	23.3	17.1	13.2	13.2
Numerator	88	88	67	52	52
Denominator	361160	377360	391047	394010	394010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
ICD10 Codes are not available at this time for 2009. Data entered was from 2008. The data may be available later in December 2010.

Notes - 2008
Data is preliminary, data will be available in December 2010.

Motor vehicle (traffic related) ICD-10 codes V02-V04 (.1,.9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8) and V89.2 listed as underlying cause of death were used to compile the data.

Notes - 2007
Data is preliminary, data will be available in December 2010.

Motor vehicle (traffic related) ICD-10 codes V02-V04 (.1,.9), V09.2, V12-V14 (.3-.9), V19 (.4-.6), V20-V28 (.3-.9), V29-V79 (.4-.9), V80 (.3-.5), V81.1, V82.1, V83-V86 (.0-.3), V87 (.0-.8) and V89.2 listed as underlying cause of death were used to compile the data.

Narrative:
/2010/ This data is from Vital Statistics, death certificates and Child & Family Services. As part of the Child Death Review Administrative Team, the members have worked with the Department of Public Safety to develop campaigns to promote healthy driving. The Injury Prevention

surveillance has provided data to help target these campaigns. A campaign called "Click it or Ticket" promoted the use of seat belts. The Administrative Team evaluates each death and with the participation of the Attorney General identifies those areas where state law could be changed or newly enacted to prevent child deaths. For example, the Team worked with partners and identified legislators to change Nevada driver's license law to a graduated driver's license for adolescents. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	162.5	141.7	129.0	138.3	138.3
Numerator	855	779	735	794	794
Denominator	526084	549579	569703	573966	573966
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Hospital discharge data will not be available, data will be available in December 2010. Data entered is from 2008.

Notes - 2008
ICD-9 codes 800-909.2,909.4, 909.9, 910-994.9, 995.5-995.59,995.80-995.85 listed as primary diagnosis and discharge status "Alive" were used to compile the hospital discharge data.

Notes - 2007
ICD-9 codes 800-909.2,909.4, 909.9, 910-994.9, 995.5-995.59,995.80-995.85 listed as primary diagnosis and discharge status "Alive" were used to compile the hospital discharge data.

Narrative:
/2010/ This data is from Vital Statistics. The Child Death Teams, Executive, Administrative and local, form the focus of Nevada's death and injury prevention activities. Local teams produce reports that are widely distributed to increase public knowledge of issues with child injury and death in the state. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	35.2	25.3	14.9	13.6	13.6
Numerator	185	139	85	78	78
Denominator	526084	549579	569703	573966	573966
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Hospital discharge data will be available in December of 2010. Data entered was from 2008.

Notes - 2008
ICD-9 codes E810-E819 (.0-.9) and discharge status 'Alive" were used to compile the discharge data.

Notes - 2007
ICD-9 codes E810-E819 (.0-.9) and discharge status 'Alive" were used to compile the discharge data.

Narrative:
/2010/ This data is from Vital Statistics. As previously noted, the state's Child Death Review teams are the focus of state initiatives to prevent child injury and death. They are based in the Division of Child and Family Services which is charged with preventing child abuse and neglect. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	145.9	121.1	74.9	94.7	94.7
Numerator	527	457	293	373	373
Denominator	361160	377360	391047	394010	394010
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Hospital discharge data will be available in December of 2010. Data entered was from 2008.

Notes - 2008
ICD-9 codes E810-E819 (.0-.9) and discharge status 'Alive" were used to compile the discharge data.

Notes - 2007
ICD-9 codes E810-E819 (.0-.9) and discharge status 'Alive" were used to compile the discharge data.

Narrative:

//2011// Please see notes on NPM 16 and SPM 10. 2009 data not available, data shown is 2008.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	13.1	14.1	28.2	28.2	28.2
Numerator		1259	2613	2630	2630
Denominator		89473	92701	93403	93403
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2009 population is not available. Data may be available in December of 2010. Data entered is 2008 data.

Notes - 2008
Wrong population was used for 2007, data was corrected to just female 15-19 in 2008.

Notes - 2007
Wrong population was used for 2007, data was corrected to just female 15-19.

Narrative:
/2010/ This data is from NSHD Communicable Disease program. The Bureau has a Sexually Transmitted Disease program that addresses adolescents and women of child bearing age. This initiative is through the public health nurses in rural and frontier counties. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	5.4	6.6	8.8	8.9	8.9
Numerator		3056	4225	4309	4309
Denominator		462416	479159	482761	482761
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Population data should be available in December of 2010. Data entered was 2008 data.

Notes - 2008
EPI gave population for both male & female. This data was corrected to just female 15-19 in 2008.

Notes - 2007
EPI gave population for both male & female. This data was corrected to just female 15-19.

Narrative:
./2010/ This data is from NSHD Communicable Disease program. The Bureau has a Sexually Transmitted Disease program that addresses adolescents and women of child bearing age. This initiative is through the public health nurses in rural and frontier counties. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	40981	19413	3252	503	2538	0	0	15275
Children 1 through 4	154944	71633	12470	1962	11119	0	0	57760
Children 5 through 9	188792	91960	15213	2602	11604	0	0	67413
Children 10 through 14	189249	99497	16804	2745	10973	0	0	59230
Children 15 through 19	194034	102274	17307	3107	11154	0	0	60192
Children 20 through 24	199975	106654	14818	2993	12832	0	0	62678
Children 0 through 24	967975	491431	79864	13912	60220	0	0	322548

Notes - 2011

Narrative:
/2010/ This data is from the state demographer and the U.S. Census updated by the demographer and Vital Statistics. It emphasizes how Nevada continues to grow. Although it lost its number 1 ranking for growth, it is still experiencing growth and we see major impacts from the sluggish economy. The impact of growth is discussed in the Overview and throughout this document. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	25706	15275	0

Children 1 through 4	97184	57760	0
Children 5 through 9	121378	67413	0
Children 10 through 14	130019	59230	0
Children 15 through 19	133843	60192	0
Children 20 through 24	137297	62678	0
Children 0 through 24	645427	322548	0

Notes - 2011

Narrative:
/2010/ This data is from the state demographer and the U.S. Census updated by the demographer and t and Vital Statistics. . It emphasizes how Nevada continues to grow. Although it lost its number 1 ranking for growth, it is still experiencing growth and we see major impacts from the sluggish economy. The impact of growth is discussed in the Overview and throughout this document. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	67	54	9	1	2	0	0	1
Women 15 through 17	1440	1135	201	18	45	0	0	41
Women 18 through 19	2752	2112	413	53	98	0	0	76
Women 20 through 34	29219	22950	2737	401	2368	0	0	763
Women 35 or older	5296	4053	364	47	693	0	0	139
Women of all ages	38774	30304	3724	520	3206	0	0	1020

Notes - 2011

Narrative:
/2010/ This data is from birth certificates. See HSI # 1 -- 4 for a discussion of Bureau and partner initiatives to promote healthy birth outcomes. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	20	43	4
Women 15 through 17	568	826	46

Women 18 through 19	1375	1311	66
Women 20 through 34	17474	11262	483
Women 35 or older	3486	1738	72
Women of all ages	22923	15180	671

Notes - 2011

Narrative:
/2010/ This data is from birth certificates. See HSI # 1 -- 4 for a discussion of Bureau and partner initiatives to promote healthy birth outcomes. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	259	197	45	0	11	0	0	6
Children 1 through 4	67	55	11	0	1	0	0	0
Children 5 through 9	21	17	2	0	1	0	0	1
Children 10 through 14	37	28	4	0	4	0	0	1
Children 15 through 19	110	87	21	1	0	0	0	1
Children 20 through 24	201	166	27	0	4	0	0	4
Children 0 through 24	695	550	110	1	21	0	0	13

Notes - 2011

Narrative:
/2010/ This data is from death certificates and population data on race and ethnicity. See HSI # 3A through 4C for the discussion of Bureau and partner initiatives to prevent child and youth injury and death. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	178	86	1
Children 1 through 4	45	22	0
Children 5 through 9	13	8	0

Children 10 through 14	27	11	1
Children 15 through 19	85	25	1
Children 20 through 24	149	54	1
Children 0 through 24	497	206	4

Notes - 2011

Narrative:
/2010/ /2011/This data is from death certificates and population data on race and ethnicity. See HSI # 3A through 4C for the discussion of Bureau and partner initiatives to prevent child and youth injury and death. //2010////2011//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	768000	384777	65046	10919	47388	0	0	259870	2008
Percent in household headed by single parent	34.0	51.0	9.0	2.0	6.0	0.0	0.0	33.0	2008
Percent in TANF (Grant) families	2.0	63.0	27.0	2.0	2.0	0.0	5.0	1.0	2008
Number enrolled in Medicaid	186581	57857	36501	2202	4198	0	5770	80053	2009
Number enrolled in SCHIP	34036	6373	1865	226	818	0	1553	23201	2009
Number living in foster home care	10931	5859	2475	209	303	0	0	2085	2008
Number enrolled in food stamp program	67832	44904	17637	1085	2102	68	1694	342	2008
Number enrolled in WIC	70228	14326	6476	473	2060	0	0	46893	2009
Rate (per 100,000) of juvenile crime arrests	881.6	687.1	184.0	8.6	19.7	0.0	0.0	0.0	2008
Percentage of high	4.8	3.6	6.2	4.6	0.0	3.4	0.0	6.8	2007

school drop-outs (grade 9 through 12)									

Notes - 2011

Narrative:
/2010/ This data is from multiple sources as indicated in the online form notes. WIC is part of the Bureau and is experiencing great growth, reaching 66,000 in this year and on projected for 70,000 participants by year end. The Bureau partners with the Division of Health Care Financing and Policy, the Welfare and Supportive Services Division, the Justice Department, Department of Education and others for reported data. Compiling data from different sources requires some data cleaning, and shows the inconsistencies in the ways race and ethnicity are indicated on different data sets. Discussion of MCH activities around these issues and enrollments are discussed throughout this document. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	483840	284160	0	2008
Percent in household headed by single parent	21.0	13.0	0.0	2008
Percent in TANF (Grant) families	2.0	1.0	0.0	2008
Number enrolled in Medicaid	110235	76346	186581	2009
Number enrolled in SCHIP	10835	23201	34036	2009
Number living in foster home care	8846	2085	0	2008
Number enrolled in food stamp program	50173	17659	0	2008
Number enrolled in WIC	25654	44574	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	881.6	2008
Percentage of high school drop-outs (grade 9 through 12)	4.2	6.8	0.0	2007

Notes - 2011

Narrative:
/2010/ This data is from multiple sources as indicated in the online form notes. WIC is part of the Bureau and is experiencing great growth, reaching 66,000 in this year and on projected for 70,000 participants by year end. The Bureau partners with the Division of Health Care Financing and Policy, the Welfare and Supportive Services Division, the Justice Department, Department of Education and others for reported data. Compiling data from different sources requires some data cleaning, and shows the inconsistencies in the ways race and ethnicity are indicated on different data sets. Discussion of MCH activities around these issues and enrollments are discussed throughout this document. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	677204
Living in urban areas	692753
Living in rural areas	11907
Living in frontier areas	63340
Total - all children 0 through 19	768000

Notes - 2011

Narrative:
/2010/ This data came from the state demographer's projections of the census data. The Bureau monitors the population and economic status of state residents for all of its programs, from projecting potential WIC participants to identifying CYSHCN and to target outreach and media campaigns appropriately. The Bureau works to ensure those most at risk have the services they need through partnership and collaborations. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2783733.0
Percent Below: 50% of poverty	4.9
100% of poverty	10.3
200% of poverty	29.2

Notes - 2011

Narrative:
/2010/The Bureau monitors the population and economic status of state residents for all of its programs, from projecting potential WIC participants to identifying CYSHCN and to target outreach and media campaigns appropriately. The Bureau works to ensure those most at risk have the services they need through partnership and collaborations.//2011//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	768000.0
Percent Below: 50% of poverty	6.0
100% of poverty	14.0
200% of poverty	38.0

Notes - 2011

Narrative:

/2010/ This data came from the state demographer's projections of the census data. The Bureau monitors the population and economic status of state residents for all of its programs, from projecting potential WIC participants to identifying CYSHCN and to target outreach and media campaigns appropriately. The Bureau works to ensure those most at risk have the services they need through partnership and collaborations. //2010//

F. Other Program Activities

Nevada's Maternal and Child Health Block Grant continues to provide funding for Early Intervention Services to improve services for CYSHCN and early identification. The Bureau also partners with BEIS whose clinics provide the site for the Bureau's multidisciplinary clinics in Reno and Las Vegas (metabolic, genetic, FASD).

The Nevada WIC Program's Electronic Benefit Transfer (EBT) initiative is being implemented. The EBT (smart) card is very popular with the WIC clinics, participants and partners. Participants only procure those foods that their families need, and can go as often as they like to the grocery store as they are not tied to purchasing everything that is listed on a voucher on one visit to the store. Clinics like the paperless aspects; staff can serve more people in a given time period than with a paper voucher. Vendors like it as it has eliminated checker problems and bill backs. They are also reimbursed overnight as opposed to getting paid in the several weeks it takes for paper. As previously mentioned WIC is a program of the Bureau's and under the supervision of the MCH Chief.

The Bureau continues to have three toll-free information lines. The first and primary is the MCH Campaign's 1-800-429-2669. In 2006 it had 1,077 calls. In 2008 it had calls. The second line is the CSHCN line, 1-866-254-3946. It had 1,302 calls in 2006. In 2008 it had calls. The third and final line is the WIC line, 1-800-8 NEV WIC. It is now being answered in the Bureau. All three lines have outreach initiatives. They are all bilingual, English and Spanish. They all tie into the State's Nevada 2-1-1 line. New in 2010, the MCH Campaign line will be

The State in the next biennium is putting several resources together to develop a system for autism screening and referral for all children. The 2007 Legislature appropriated Two million dollars to DHHS for an advisory committee and to allocate to families to help them with the expenses of having a child with autism. The Health Division is charged with developing the system; the project is located in the Administrator's Office. The Bureau will take the calls that come in from the autism media campaign (and other sources), forward an intake form by e-mail to the autism office who will send out an Ages and Stages questionnaire for parents/guardians to complete and return. The office will score it and be in charge of follow-up. The Bureau is also working with the autism office through the ECCSD project to get the screening tool widely distributed, with the state goal of screening all children at age 18 months (or older).

The Bureau is partnering with the Department of Health and Human Services' Statewide Headstart Office for implementation of the Early Childhood Comprehensive Systems Development (ECCSD). Nevada successfully applied for future ECCS funding. A statewide Early Childhood Advisory Board will be formed and coordinate activities with existing boards such as the Interagency Coordinating Council and the Maternal & Child Health Advisory Board. Foster care organizations and child care organizations are also participating.

G. Technical Assistance

New TA Requests for 2010.//2011//
/2010/ /2011/Nevada has a wide variety of technical assistance requests, please see Form 15 for

details. More specifically, Nevada's Technical Assistance and Training Center on Autism is looking to the Association of Maternal Child Health Programs' State Public Health Coordinating Center for Autism (STHCCA), to provide technical assistance on
• Standards for care coordination • Materials and strategies for rural/hard to reach populations • Materials for Hispanic families • Engagement of advisory groups • Strategies around training providers • Best practices around reimbursement. Within breastfeeding support, Nevada wishes to learn from the Oregon Nursing Mother's Council how it interacts with the State WIC Program, how it is funded, and who its partners are. Our Prenatal Substance Abuse Prevention Program is very interested in developing a partner-driven strategic 5-year plan. In the area of School Health, Nevada would like to learn from the CDC what the next steps are to move Nevada into obtaining the Coordinated School Health funding at the next FOA. Nevada requests technical assistance in building our adolescent health programs and incorporating these into MCH. Specific to data, Nevada State Health Division has several new biostatisticians who have expressed a desire to learn more in depth analysis, techniques and planning around Title V and Epi data.
/2010////2011/////

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1837036	1777645	1792997		1792466	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	1377777	1377777	1344748		1344350	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	3214813	3155422	3137745		3136816	
8. Other Federal Funds *(Line10, Form 2)*	47946657	18521626	69573483		18521626	
9. Total *(Line11, Form 2)*	51161470	21677048	72711228		21658442	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1361456	1396717	1112846		1209918	
b. Infants < 1 year old	0	0	769802		672175	
c. Children 1 to 22 years old	725961	645841	537899		537740	
d. Children with	943693	960963	537899		537743	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	183703	151901	179299		179240	
g. SUBTOTAL	3214813	3155422	3137745		3136816	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		0		0	
c. CISS	140000		0		0	
d. Abstinence Education	280186		280174		194139	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	45947642		48258837		0	
h. AIDS	0		12287073		0	
i. CDC	990496		8129205		8994681	
j. Education	0		0		0	
k. Other						
EDHI	0		0		150000	
First Time Mothers	0		0		500000	
Ryan White	0		0		8482806	
SPNS	0		0		200000	
FTM/HRSA	0		500000		0	
NBHS/HRSA	0		118194		0	
Other - See Notes	493689		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	877660	575611	545587		650264	
II. Enabling Services	796441	539930	379299		482055	
III. Population-Based Services	1002906	1821270	1878158		1637007	
IV. Infrastructure Building Services	537806	218611	334701		367490	
V. Federal-State Title V Block Grant Partnership Total	3214813	3155422	3137745		3136816	

A. Expenditures

Form 3, State MCH Funding Profile shows FY 2009 MCH expenditures amounted to $1,777,645 with the appropriate expenditure match of state funds adhering to the required 3:4 match of three (3) state dollars for every four (4) federal dollars. The State expenditure amount for a total of $3,155,422. The MCH budget for FY 2009 was $3,,214813. Nevada's MCH expenditures were decreased over the budgeted amount. This decrese was in part due to lower federal allocation.

Other federal funds expended during FY 2009 amounted to $21,677,048. This compares with the

budgeted amount of $51,161,470 this decrease is due to the change in structure and WIC budge was not expended under MCH direction.

Form 4, Budget Details by Types of Individuals Served provides the detail for budget expenditure variances by population served. Pregnant Women included budgeted federal expenditures of $1,361,456 and actual expenditures amounted to $1,396,717in FY 2009. The budget expenditure variance for Pregnant Women is $35,261, or 9% above the amount budgeted. In past years, the Pregnant Women category included expenditures for included newborn screening. This year, the amount was split to show more accurately the amount expended on newborns in the "Infants < 1 year old category. The amount budgeted was $0.00.

Form 4 for FY 2009 for Children 1 to 22 Years Old budgeted $725,961 and expenditures amounted to $645,841. The expenditure decrease is in part due to salaries not spent.

Form 4 for FY 2009 for Children with Special Health Care Needs included budgeted amount of $943,693 and expenditures of $960,963. Federal expenditures for Children with Special Health Care Needs amounted to 33% of federal funds expended in FY 2009.

Form 4 for FY 2009 for Administrative costs, included budgeted expenditures of $183,703 and actual expenditures amounted to $151,901. This was the allowed amount of 10% for Administrative expenditures per grant guidance.

Form 5, State Title V Program Budget and Expenditures by Type of Service, Direct Health Care Services for FY 2009 included budgeted of $877,660 and actual expenditures amounted to $575,611. The budget variance for this group is a decrease of $302,049, this decrease was due to new budgeting methodology direct services of EIS and community nursing.

Form 5, State Title V Program Budget and Expenditures by Type of Service, Enabling Services for FY 9 included budgeted expenditures of $796,441 and actual expenditures amounted to $539,930, with MCH funds $484,436 and MCH Campaign at $55,494 . The budget variance for this group is an decrease of 33% new budget methodology using actual expenditures.

Form 5, State Title V Program Budget and Expenditures by Type of Service, Population-Based Services for FY 2009 included budgeted expenditures of $1,002,906 and actual expenditures amounted to $1,821,270. The budget variance for this group is an increase of $818,364, or 45% above the amount budgeted. The budget variance is due to categorizing expenditures by function of activity versus only population served for a more accurate estimation of the amount expenditures. (TVIS keywords were used as a guide for sorting expenditures.

Form 5, State Title V Program Budget and Expenditures by Type of Service, Infrastructure Building Services for FY 2009 included budgeted expenditures of $537,806 and actual expenditures amounted to $218,611. The budget variance for this group is a decrease of $319,195, below the amount budgeted. The variance is based on how the dollars are categorized. Staff have clearer understanding of activities that fall within Infra-structure building and new performance measures are heavy on activities which are infrastructure building. Also new contracts will include deliverables that contribute to the infrastructure building category. A new system for showing detail within contracts versus broadly categorizing contracts into one category will be used in the future to more accurately track progress toward drilling down into the MCH pyramid.

B. Budget

Next year's budget, Federal Fiscal Year (FFY) 2010 MCH application budget adheres to the required 3:4 match of three (3) state dollars for every four (4) federal dollars. The federal MCH portion is estimated, for budget planning purposes at $1,792,997. The 75% state MCH match,

budgeted at $1,344,748 is comprised of fees generated by the Newborn Screening program. The total FFY 2010 MCH budget is $3,137,745. As required, the FFY 2010 MCH budget exceeds the required FFY 1989 Maintenance of Effort amount of $853,034. As with previous years, the actual match will likely exceed the budgeted match as more fees are generated for each birth. All fees are expended for newborn screening activities (contributing to the 30% CYSHCN requirement).

For FY 2010, 30% of the federal Title V allocation (Form 2, Section 1.A) is budgeted for Preventive and Primary care for children and adolescents that equals $537,899. We expect as in prior years to surpass the 30% minimum. Working with our MCH Advisory Board members and county health district representatives, we are in the process of issuing new contracts for services. In the past, most contracts were for direct services and had been renewed up to 14 years in some cases. Nevada MCH is working to allocate the dollars to current priorities and budget the activities to more proportionally meet the MCH pyramid recommendations. We are decreasing the amount of Direct Care Services proportionally, designing the next in quantity to be Enabling Services, increasing the amount of Population-Based Services, and building our base of Infrastructure building services. Our short term goal will be an improved diamond shape, with more public health functions being added over time. In the past, direct health care services have been primary care and oral health oriented, as these represent two significant unmet needs for children and adolescents. While, we still consider these important areas, the function of how the MCH dollars will be used is shifting. For example, money may be contracted to address the same areas, but to include monitoring and quality assurance, advocacy, and policy development activities. The MCH Advisory board is increasing their advocacy role and will be quarterly monitors of the MCH contracted dollars. This is part of the shift to move toward a public health approach emphasizing prevention and primary care to improve health outcomes for children and adolescents. In the current year, the MCH AB developed their priority areas: Access to prenatal care, Immunization rates, Dental sealants, and access to mental health services (standard behavioral health screens). Projects in FFY 2010 are being designed to address their priorities and manage as many areas of need as possible./2011///2011//

For FFY 2010, 30% of the federal Title V allocation (Form 2, Section 1.B) is budgeted for Children with Special Health Care Needs and their families in the amount of $537,899. We expect as in prior years to surpass the 30% minimum. Nevada MCH is in the process of redesigning their health coverage program for CYSHCN and reviewing how the dollars are used for Early Intervention Services. MCH staff, the Interagency Coordinating Council, and the Nevada Advisory Council for CYSHCN are involved in the redesign. In the past, direct services have been provided by Nevada Early Intervention Services and through health professionals, such as pediatric ophthalmologists and physical therapists who are under contract to the CYSHCN program. In FFY 2009 all these services were provided through the Nevada Early Intervention Services in Reno and Las Vegas and CSHCN staff based in Carson City.

For FFY 2010, Administrative costs, Form 2, Section 1. C $179,299 is budgeted. Expenditures will not exceed this amount of 10%. For FFY 2010, the remaining federal Title V award is directed towards services for pregnant women and postpartum women and infants up to age 1 year; and designing other activities directed to MCH populations statewide. Direct and population-based services are provided through contracts with local agencies, including health districts and community based non-profit agencies. Requests for Information are out to the community to assist in rewriting the new contracts' competitive process and scope of work.

Last year's note indicated Nevada's MCH unexpended grant balance of $150,000, was "basically expended as planned over the current 2007-2008 biennium." However, it shows up in the budgeted amount again. As the dollars were previously expended, the budget line item will zero out this year. Nevada's Title V Maternal and Child Health Block grant is fully budgeted for a two year period, through the Legislative process for the 2010-2011 biennium.

Other federal funds administered by the MCH Chief in addition to the Maternal and Child Health Title V Block Grant Program include a Oral Health, Rape Prevention and Education, Early

Hearing Detection from CDC; and Sexual Assault Prevention from PHHS. Other federal grants include Breast and Cervical Cancer, Newborn Hearing Screening, Ryan White, HIV prevention, diabetes and tobacco and Immunizations from CDC, that provide different services to the populations served by the Maternal and Child Health Block Grant Program in accordance with approved grant proposals.

For FFY 2011 our budgeted amount in federal allocation is $1,792466 with preventative and primary care for children amounting to $537,740 or 30% and $537,740 for Children with special health care needs, although its expected MCH will spend more than budgeted for this category. State MCH funds which account for 75% of newborn screening fees or $1,344,350 this number may vary depending on birth rates which are in a decline for the past few years. Total state match is budgeted for in 2011 at $3,136,816. Total MCH budget for 2011 is projected at $21,658,442.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.